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A Study on the Perception and Awareness of Nutritional Requirements in Cab Drivers

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Abstract:
Cabs are a vital part of urban transportation, facilitating mobility within cities, connecting people to their destinations, and contributing to the urban fabric. This study aims to explore the perception and awareness of nutritional requirements among cab drivers, a demographic often overlooked in discussions surrounding health and well-being. The study will involve data collection from 50 drivers operating in urban areas, with considerations for factors such as age, gender, years of experience, and working hours. Moreover, this research would highlight the broader societal implications of improving the nutritional health and overall wellbeing of the cab driver population, emphasizing the potential ripple effects on individual health outcomes, workplace productivity, and overall community health. In essence, this research serves as a call to action for policymakers, healthcare professionals, and community stakeholders to prioritize the nutritional needs and implement targeted interventions that empower them to make healthier choices.

INTRODUCTION

An individual as a component of this world has an inherent responsibility to take care of oneself and function as a part of this universe. This requires the human to fulfill various needs for his survival, they range from physical to social factors. However out of those the physiological needs, nutrition is of prime significance as it is required for the basic survival of an individual and henceforth allow to fulfill the rest of the factors. The human body cannot function optimally if physiological needs are not satisfied. It is considered the most important as all the other needs become secondary until these needs are met. Physiological needs are biological requirements for human survival, e.g., air, food, drink, shelter, clothing, warmth, sex, and sleep.

Food is the most significant source of survival for all living organisms, including humans. It provides the required nutrients, energy, and sustenance for bodily functions. Without adequate food intake, individuals would experience malnutrition, weakness, and ultimately, death.

The basic components of food include macronutrients such as carbohydrates, proteins, and fats, which serve as the primary sources of energy and building blocks for muscles. They are required at larger amounts when compared with other nutrient category as the form the foundation for the survival of the individual. Carbohydrates are the body's primary fuel. They provide energy for muscles and the central nervous system during movement and exercise. Protein is essential to many processes in the body. It provides structure to the tissue. That includes cell membranes, organs, muscle, hair, skin, nails, bones, tendons, ligaments, and blood plasma. Proteins are involved in metabolic, hormonal and enzyme systems and help maintain acid-base balance in our bodies.

The federal Acceptable Macronutrient Distribution Range suggests that the carbohydrate is required 45-65%,20-35% of fat,10-35% of protein. The Dietary Guidelines for Americans, 2020–2025 suggests similar values, but notes that people's calories and macro requirements can vary due to factors such as age, sex, pregnancy, muscle mass. Additionally, micronutrients such as vitamins and minerals are essential for various physiological processes, including metabolism, immune function, and tissue repair. Micronutrients are essential for the body's proper functioning in minimal amount. Despite their minimal requirement, it impacts health hugely, and deficiencies can lead to severe, even fatal conditions. These nutrients play significant roles, facilitating enzyme, hormone, and other vital substance production crucial for normal growth and development.

Notably, deficiencies in iron, vitamin A, and iodine are widespread globally, particularly among children and pregnant women. Low- and middle-income countries face a disproportionate burden of such deficiencies. It is also quite seen in developing country such as India where there is a huge difference economic inequality among the population.

The consequences of micronutrient deficiencies extend beyond visible health issues, encompassing subtle yet impactful reductions in energy levels, mental clarity, and overall capacity. This can result in compromised educational outcomes, diminished work productivity, and heightened susceptibility to other diseases and health conditions.

Fortunately, many of these deficiencies are preventable through comprehensive strategies like nutrition education, promoting diverse and balanced diets, and implementing food fortification and supplementation programs where necessary. While significant progress has been made in recent decades, further efforts are imperative to address micronutrient deficiencies

Nutrition is a dynamic field that focuses on the complex relationship between the living organism and the substances they consume to grow, develop and survive. nutrition looks into the bio-chemical interactions between the dietary components and the human autonomy. It involves the complete process of procurement, consumption, assimilation, storage, utilization and finally the excretion of the nutrients. Nutrition the systematic study of nutrients that produce the nourishment required for maintenance of life, building the body, fulfilling energy requirements, reproduce, repair and proper functioning of the body.

Nutrition plays a fundamental role in human health across all stages of life. The relationship between nutrition and health is intricate and multidimensional, influencing various aspects of physical, mental, and even social well-being. Proper nutrition is essential for the proper functioning of the body's physiological processes. Essential nutrients such as proteins, carbohydrates, fats, vitamins, and minerals are required for energy production, tissue repair, hormone regulation and immune function.

Lack of nutrition can lead to a range of health problems, including malnutrition, obesity, cardiovascular diseases, diabetes, osteoporosis, and certain types of cancer. Nutrition is one of the essential matters for a human to have the proper sequential order of developmental stages, starting from infant to elderly. During periods of growth, such as infancy, childhood, adolescence, and pregnancy, proper nutrition is crucial for optimal growth and development. Nutrient deficiencies during these critical periods can result in stunted growth, cognitive impairments, and other developmental issues. Poor nutrition also hampers the normal bodily changes at each stage that may become a obstacle to their growth.

Nutrition plays a significant role in supporting a healthy immune system. Certain nutrients, such as vitamins A, C, D, and zinc, are particularly important for immune function and can help the body fight off infections and illnesses. Its impact was heavily felt during the pandemic when malnourishment paved way to easy infection by the Covid virus. It at the same time hampers or prolongs the recovery process making

it difficult for the body to fight against pathogens. Nutrition has the power to influence various aspects of health. Its influence does not stop with physical wellbeing but also reaches psychological wellbeing. Recent research suggests that nutrition also plays a role in mental health and emotional well-being. Certain nutrients, such as omega-3 fatty acids, folate, and antioxidants, have been associated with improved mood regulation and cognitive function. In contrast to poor dietary patterns such as high intake of processed foods, sugar, and unhealthy fats have been linked to an increased risk of depression, anxiety, and other mental health disorders.

The history of human nutrition dates back to the dawn of civilization. Human diet was largely and basically determined by the availability of foods. Hippocrates, the Greek physician and the Father of Medicine, was amongst the first to establish the role of diet in human wellbeing, through his sayings “let food be your medicine”. He proposed daily modifications in lifestyle such as diet habits and exercise to treat diseases. In many historical periods and cultures, people indeed had various ideas about nutrition, taboos surrounding food, medicinal powers attributed to certain foods, and the availability of different types of food. These beliefs and practices often varied widely depending on factors such as geographical location, cultural traditions, religious beliefs, and prevailing medical knowledge.

Diets were often dictated by what was locally available and could vary greatly from region to region. Staple foods might include grains, legumes, vegetables, fruits, and occasionally meats or fish depending on factors like climate and access to resources. There was less awareness of specific nutrients like proteins, carbohydrates, fats, and vitamins. Many foods and herbs were believed to possess medicinal properties, and they were often incorporated into traditional medical practices such as ayurvedha. In some regions, food was abundant and diverse, while in others, scarcity was a constant challenge. Famine and food shortages were common throughout history, leading to malnutrition and starvation in many communities. Although food and nutrition have been studied for centuries way before start of civilizations, modern nutritional science is surprisingly young. The first vitamin was isolated and studied in 1912, almost 112 years ago. In 1912 Polish-born biochemist Casimir Funk, working in London, isolated the complex of micronutrients and proposed the complex be named "vitamine". It was later to be known as vitamin B_3 (niacin), though he described it as "anti-beri-beri-factor" (which is today called as thiamine or vitamin B_1).

Research on the role of nutrition in complex non-communicable chronic diseases, such as cardiovascular disease, diabetes, obesity, and cancers, is even more recent, accelerating over the past two or three decades and especially after 2000. The first half of the 20th century witnessed the identification and synthesis of many of the known essential vitamins and minerals and their use to prevent and treat nutritional deficiency related diseases including scurvy, beriberi, pellagra, rickets etc. with time they were soon chemically synthesized to be provided as supplements to fulfil the deficiency among the humans. It was a blooming market that was able to prevent various diseases and saved thousands of individuals from fatal conditions. This paved a way for modern day use and marketing of individual and bundled multivitamins to guard against deficiency, launching an entire vitamin supplement industry.

This new ideology of single nutrient deficiency diseases also led to fortification of selected staple foods with micronutrients, such as iodine in salt and niacin (vitamin B_3) and iron in wheat flour and bread. Iodized salt was introduced to India in the late 1950s to decrease the raise of Goiter cases. the first recommended dietary allowances (RDAs) were an outcome of these mater, when the League of Nations, British Medical Association, and the US government separately commissioned scientists to generate new minimum dietary requirements to be prepared for war.

During the next 1950s to 1970s, energy malnutrition and specific vitamin deficiencies fell sharply in high income countries because of economic development and large increases in low cost processing of staple foods fortified with minerals and vitamins. At the same time, the rising burdens of diet related non-communicable diseases began to be recognized, leading to new research in two areas: fat and sugar. In less wealthy developing countries, the main objectives of nutrition policy and recommendations during this period remained on increasing calories and selected micronutrients as they have yet not satisfied the basic calorie need of an individual.

Accelerating economic development and modernization of agricultural, food processing, and food formulation techniques continued to reduce single nutrient deficiency diseases globally. There was a significant fall in the mortality rate but however various chronic disorders such as diabetes, cardiovascular disorders started to rise in exponential amount. This led to a proliferation of industrially crafted food products low in fat, saturated fat, and cholesterol and fortified with micronutrients, as well as expansion of other nutrient focused technologies to reduce saturated fat such as partial hydrogenation of vegetable oils.

In recent years, there has been a growing interest in the field which explores the interaction between nutrition and genetics. It focuses on how individual genetic variations affect responses to nutrients and dietary patterns. It aims to understand how genetic differences between individuals influence their nutritional requirements, metabolism, and susceptibility to diet-related diseases. This personalized approach to nutrition takes into account an individual's genetic makeup, lifestyle, and environmental factors to optimize dietary recommendations. However, it has been facing various ethical opposition.

Malnutrition refers to a condition where an individual's diet lacks the proper balance of nutrients needed for optimal health and well-being. It can manifest in different forms, including undernutrition, over nutrition, and micronutrient deficiencies, each with its own set of health implications. Undernutrition occurs when an individual does not consume enough calories, protein, or other essential nutrients to meet their body's needs. It can lead to conditions such as stunting (impaired growth and development), wasting (severe weight loss), and underweight. Undernutrition weakens the immune system, increases susceptibility to infections, impairs cognitive development, and can be particularly detrimental in children, leading to long-term health problems.

Over nutrition, on the other hand, involves consuming more calories and nutrients than the body requires, often leading to obesity and associated health issues such as type 2 diabetes, cardiovascular disease, hypertension, and certain types of cancer. Over nutrition is often linked to excessive consumption of high-calorie, processed foods that are low in nutritional value but high in sugar, unhealthy fats, and salt. Malnutrition can also result from inadequate intake of vitamins and minerals essential for various bodily functions. Micronutrient deficiencies, such as lack of vitamin A, iron, iodine, and zinc, can impair immune function, increase the risk of infections and diseases, hinder cognitive development, and lead to other health problems.

According to a United Nations report, the global number of individuals impacted by hunger surged to approximately 828 million in 2021, marking an increase of around 46 million compared to 2020 and 150 million since the onset of the COVID-19 pandemic. This data offers new insights, indicating a significant setback in the world's progress towards achieving the goal of ending hunger, food insecurity, and malnutrition in all its manifestations by 2030.

The United Nations Sustainable Development Goal (UNSDG) 2, known as Zero Hunger, sets the ambitious objective of eradicating hunger worldwide by 2030 and addressing malnutrition

comprehensively. However, according to the United Nations' own assessments, current progress suggests a significant shortfall in meeting this target. Reports indicate that approximately 150 million children worldwide are affected by stunting, while 41 million children under the age of 5 are classified as obese. Moreover, one in three individuals faces challenges in accessing sufficient and nutritious food regularly, while around one in ten people suffer from hunger-related issues. India is the largest contributor of undernourished people in the world with around 194.4 Million people, or 14.37% of its population not receiving enough nutrition.

According to the 4th National Family Health Survey conducted in 2014-2015 states that 25%of men in India suffer from anemia and 16% of men under 50 are malnourished. The prevalence of overweight/obesity among men almost doubled from 2005-06 to 2015-16 according to the consecutive National Family Health Survey reports. The risk of underweight is highest in the central and western regions and was also relatively high among those who is either smoking or consuming tobacco. Overweight/obesity was more prevalent in urban areas, in the southern region, and among adults aged 35-49.

In India, the share of underweight adults is the highest globally, even as the country experiences an ongoing rise in overweight/obesity. The determinants of the dual burden of malnutrition differ considerably based on gender, socioeconomic, and behavioral factors. Economic status has emerged as an important determinant of overweight/obesity, particularly in developing countries and poorly educated and socially disadvantaged adults tend to be underweight. Studies also suggest that several risk factors are associated with low and high body mass index (BMI), including physical inactivity, poor diet, and tobacco use.

When we tend to study nutritional requirements of a human being, we tend to use various tools that point towards the physical wellbeing of an individual and helps to plan the dietary schedule for the person. Body Mass Index (BMI) is one such metric tool used to assess a person's weight status by dividing their weight in kilograms by the square of their height in meters. It serves as a simple and cost-effective screening tool to categorize individuals into different weight categories, including underweight, healthy weight, overweight, and obesity.

In most cases BMI correlates to body fat — the higher the number, the more body fat the person may have — but it’s not accurate in various cases. BMI alone does not diagnose health.

Healthcare providers use BMI and other tools and tests to assess someone’s health status and risks.

Although BMI does not directly measure body fat, it is moderately associated with more precise methods of body fat measurement. Additionally, research indicates that BMI shows comparable correlations with various metabolic and health outcomes as these more direct measures of body fatness. Therefore, despite its indirect nature, BMI remains a valuable indicator in evaluating an individual's risk for metabolic disorders and diseases related to weight.

For adults aged 20 years and older, Body Mass Index (BMI) serves as a universal tool for interpreting weight status, regardless of gender, body type, or age. BMI ranges are associated with standardized weight status categories, facilitating easy assessment. These categories encompass a spectrum of weight classifications, each corresponding to a specific BMI range.

Individuals with a BMI below 18.5 are considered underweight, indicating a potential deficiency in body weight relative to height. A BMI falling between 18.5 and 24.9 signifies a healthy weight status, reflecting a balanced ratio of weight to height. In contrast, individuals with a BMI ranging from 25.0 to 29.9 are categorized as overweight, suggesting an excess of weight relative to height. A BMI of 30.0 or above

indicates obesity, signifying a significantly higher risk of various health complications associated with excessive body fat accumulation. These standardized weight status categories enable healthcare professionals and individuals alike to assess and monitor weight-related health risks effectively.

While Body Mass Index (BMI) is commonly utilized as a reliable indicator of obesity for the majority of individuals, it lacks the ability to provide detailed insights into body composition, such as the proportions of muscle, bone, fat, and other tissues. This limitation becomes evident in certain populations where BMI may not accurately reflect true body fat levels. For instance, individuals with high muscle mass, often athletes or weightlifters, may fall into the "overweight" category according to BMI despite being healthy and physically fit due to their increased muscle mass. Conversely, elderly individuals who are frail may appear to have a normal BMI despite having low muscle mass and a higher percentage of body fat, potentially masking health risks associated with excess adiposity.

It's important to recognize that BMI may not be equally effective for all demographic groups, including children, adolescents, pregnant women, individuals with large body frames or petite builds, and those with significant muscle mass. For these populations, BMI assessments require careful consideration and interpretation to avoid misclassification and ensure accurate evaluation of health status. Thus, while BMI serves as a valuable screening tool, healthcare professionals must apply it judiciously, considering individual characteristics and circumstances to make informed health assessments.

Individuals make dietary decisions based on economic, physiologic, psychologic, sociologic and even spiritual considerations and societal implications. Eating for an individual from high income families becomes a social and family event, an act of pleasure, that goes far beyond the ingestion of the necessary nutrients to sustain life. People eat for both pleasure and as a biological necessity. However, this is not observed in case of low-income families and especially in under developed or developing country such as India.

Economic conditions play a crucial role in determining an individual's purchasing power and, consequently, their ability to make nutritious food choices. When faced with financial constraints, they often go towards affordability than nutritional value. This can lead to a reliance on cheaper, processed food options that are high in fats, sugars, and calories but lacking in essential nutrients such as vitamins, minerals, and fiber.

An individual who has a low paying job and still has his whole family to provide to, tends to turn towards foods that can satisfy their hunger and return to their daily routine the next day. They look for affordable food items that has low nutrition and high on calories than fresh fruits, vegetables, lean proteins, and whole grains which are way above their financial strength. For individuals on a tight budget, stretching their money to feed themselves or their families becomes a primary concern.

Furthermore, the widespread availability and aggressive marketing of processed foods in lo exacerbate the issue. Convenience stores, fast-food chains, kiosks and supermarkets often dominate these areas, offering inexpensive, ready-to-eat options that appeal to individuals seeking quick and convenient meals. It is mostly noticed in individuals who work for longer hours and tighter schedule. In contrast, access to fresh, nutritious foods, such as organic produce or lean meats, may be limited, not easy or ready to consume and are not at affordable cost.

Economic conditions wield a significant influence over an individual's level of education and awareness regarding nutrition. Higher-income individuals often possess greater resources to access comprehensive nutritional information, or afford a wider array of healthier food options. They subscribe to nutrition-related magazines, cross check the information with their doctors or even hire personal dietitians, they

cultivate a deeper understanding of healthy eating practices. Access to healthcare services also tends to be more readily available to those in higher socioeconomic brackets. This enables them to receive tailored guidance on nutrition from healthcare professionals, participate in wellness programs, or attend seminars and workshops focused on dietary health. They also tend to consult their doctors for even a slightest discomfort in their body which allows them to identify the issue in their nutritional practices at the very beginning. Which in turn helps them to come to a solution and prevent the aggravation of a disease.

Conversely, individuals facing economic challenges often encounter barriers to accessing similar resources and opportunities for nutritional education. Limited financial means may restrict their ability to promote their healthy eating habits. Furthermore, the stress and time constraints associated with economic hardships can make it challenging for individuals to prioritize self-improvement activities like self-cooked meal or nutritional seminars.

Those facing economic challenges may have limited access to healthcare professionals who can provide personalized dietary advice or recommend nutritional resources. In some cases, individuals may rely on government assistance programs such as the public distribution system, which may prioritize providing basic sustenance over promoting optimal nutrition.

Economic conditions exert a significant influence on the time availability of individuals, particularly those grappling with job insecurity or working multiple jobs to make ends meet. In such circumstances, time becomes a precious commodity, often leaving little room for meal preparation or cooking elaborate, nutritious meals. Faced with time constraints, individuals may prioritize convenience over nutrition, turning to fast food or processed meals that offer quick and easy solutions to their dietary needs. These options typically require minimal preparation and can be consumed on the go, aligning well with the hectic schedules. However, while these convenient choices may offer immediate time-saving benefits, they often come at the expense of long-term health, contributing to a diet high in fats, sugars, and calories but lacking in essential nutrients.

The profession of cab driving imposes a series of unique challenges that can significantly impact dietary habits and overall health. Firstly, the nature of the job entails long hours spent behind the wheel, often leading to sedentary behavior and minimal physical activity. This lack of movement can contribute to a slower metabolism and increase the risk of weight gain or obesity-related health issues.

Cab drivers, particularly those on tight budgets, may find it challenging to afford healthier options. The average salary of a cab driver in India is around 20,000 per month which is mostly not a standardized income and may vary depending of the trips they have opted for the respective time. It may also depend on their health conditions, festive period, tourists and mobility of people. Their entire income tends to be disrupted in case of pandemic, traffic restrictions etc.

Moreover, the irregular schedules inherent in cab driving make it difficult for drivers to adhere to regular meal times or plan nutritious meals in advance. They tend to prioritize quick food options to minimize disruptions to their work schedule. Instead, they may find themselves relying on quick and convenient food options available along their routes, which typically consist of fast-food restaurants and convenience stores. These establishments often

lacks the necessary vitamins and minerals for optimal health.

Additionally, the stress and fatigue associated with navigating through traffic and dealing with demanding passengers can take a toll on cab drivers' mental and emotional well-being. In response to stress, individuals may turn to comfort foods high in sugar and unhealthy fats as a coping mechanism, further exacerbating poor dietary choices. They also can be pressurized to meet the client’s requirement hence

skipping meals or taking a long gap between their consecutive meals. They cannot afford to take regular gaps in between longer rides which too affects their nutritional choices.

Overall, the combination of long hours, irregular schedules, limited access to healthy food options, sedentary behavior, and stress can create significant challenges for cab drivers in maintaining a balanced and nutritious diet.

The sociocultural determinants are the contextual factors in shaping individual perceptions of food choice processes and configuring attitudes, habits, practices, and discourses in relation to food choices from childhood to adulthood. Nutritional perspectives does not occur in a vacuum and people make decisions based on their psycho-socio-cultural backgrounds, and they constantly try to equilibrate it with the knowledge they acquire every day. People strive to strike a balance among these factors, personal inclinations, and the knowledge they accumulate about food and eating practices over their lifetimes. Significant individuals, such as parents, family members, peers, friends, and partners, play a crucial role in shaping individuals' attitudes and behaviors towards food.

Cultural food practices encompass both tangible and conceptual elements that contribute to distinct dietary patterns observed within particular geographic regions or social communities. The aspects include the infrastructure involved in food production, transportation, and distribution, as well as the financial means to obtain food and the processes of meal preparation, including acquisition, cooking, and storage, along with the settings in which meals are consumed. On the other hand, other elements the culinary traditions specific to a culture, the established norms and customs surrounding meals, the ceremonial or ritualistic significance attached to certain foods, and the social perceptions of food in terms of status.

Food practices serve as a means of communication, expressing various aspects of individual and collective identities. Food can symbolize personal identity, group affiliation, and cultural heritage. For instance, adolescents may use consumption of "junk food" to signal belonging to a particular peer group, while healthy food choices may reflect family values and upbringing. Additionally, food gifts and sharing meals are significant ways through which individual’s express social connections and a sense of belonging within their communities.

In societies where livelihoods are closely tied to food production, such as agricultural communities, food holds deep cultural and symbolic significance beyond its utilitarian purpose. In contrast, urban societies often view food primarily as a commodity to be purchased rather than produced, reflecting a different relationship with food shaped by modernization and urbanization. At the same time, food can signify social status, with certain foods associated with wealth and refinement, while others may be linked to lower socioeconomic status or food insecurity. High-prestige nutrition consumed by the affluent may convey sophistication and luxury, whereas low-prestige foods may be indicative of economic constraints or limited access to nutritious options.

In essence, food practices serve as a multifaceted language through which individuals and communities express their identities, social connections, cultural heritage, and socioeconomic status, reflecting the complex interplay of personal preferences, social norms, and structural inequalities within society.

India is a diverse country with various regional cuisines, dietary preferences, and food traditions influenced by factors such as climate, geography, and cultural heritage. For example, the cuisine in North India is characterized by wheat-based dishes like roti (flatbread) and dal (lentils), whereas South Indian cuisine often includes rice-based dishes like dosa and idli.

In addition, India's caste system has influenced dietary practices, with certain castes adhering to dietary restrictions based on social and cultural norms. For example, some communities may avoid certain foods

like meat or onions due to religious or cultural reasons associated with their caste identity. Family dynamics and traditions play a significant role in shaping dietary habits in India. Meals are often prepared and consumed communally, with family members sharing traditional recipes passed down through generations. Additionally, food is often associated with cultural rituals and ceremonies, reinforcing traditional dietary practices.

Cab drivers, often operating in urban environments, provide essential transportation services while navigating through congested streets and varied clientele. Their work entails long, irregular hours behind the wheel, facing unpredictable shifts and traffic conditions. In this demanding profession, cab drivers encounter diverse socioeconomic and cultural landscapes, influencing their daily experiences and interactions. Their role requires adaptability, quick decision-making, and customer service skills, often with limited breaks for rest and meals. Despite the challenges, cab drivers play a vital role in facilitating mobility within cities, connecting people to their destinations and contributing to the urban fabric.

Cab drivers often face unique nutritional challenges due to the nature of their work. Long hours spent driving, irregular schedules, and limited access to healthy food options can disrupt their eating patterns and compromise their nutritional intake. The demanding nature of the job, coupled with high stress levels and sedentary behavior, may lead to unhealthy eating habits and increased risk of nutrition-related health problems such as obesity, cardiovascular disease, and diabetes.

Socioeconomic factors, including income level and access to resources, further impact cab drivers' ability to make healthy food choices. Cultural influences and peer dynamics also play a role in shaping their dietary behaviors. Addressing the nutritional needs of cab drivers requires tailored interventions that consider the specific challenges they face, including strategies to improve access to nutritious foods, promote healthy eating habits, and provide support for managing stress and maintaining overall well-being.

Food and nutrition literacy have become increasingly recognized as crucial concepts in recent years. Food literacy encompasses a diverse range of interconnected knowledge, skills, and behaviors related to the identification, management, selection, preparation, and consumption of food. It entails the ability to make informed decisions that not only promote personal health but also contribute to the sustainability of the food system, taking into account various social, environmental, cultural, economic, and political factors.

On the other hand, nutrition literacy refers to an individual's proficiency in accessing, processing, and understanding fundamental dietary information and services to make healthy food choices. This involves grasping nutritional concepts and being capable of comprehending, assessing, and applying nutrition-related information, including awareness of nutrients and their implications for health. Nutrition literacy extends to understanding how foods are metabolized, their effects on health, and utilizing this knowledge to make well-informed decisions regarding dietary practices. In essence, both food and nutrition literacy are essential for empowering individuals to navigate the complexities of modern food environments and make choices that support their health and well-being, as well as contribute to broader societal goals of sustainability and equity.

However, this nutrition literacy has not reached towards the lifestyle of taxi drivers, who can feel overwhelmed to focus on their nutritional choices with their tight professional schedule, irregular hours, lesser income etc. This has been the prime motivating factor to pursue this research to study the perspectives and awareness of nutritional requirements in cab drivers.

REVIEW OF LITERATURE

CHANEY, M. S., & AHLBORN, M. (1949) explains there are three types of hunger that can be observed in human beings. There is hollow hunger which caused due to insufficient food and is reflected in height and weight, there is hidden hunger which is caused due to unbalanced nutrition and finally the humdrum hunger which is psychological and spiritual in nature. the awareness and knowledge related to food and nutrition plays a major role in helping people to be nourished and healthy. Education to every common man concerning nutrition is the most basic step toward global nourishment. Not only professionals but every lay man has the responsibility to be self-aware and spread that knowledge in the community to defend themselves and the world from nutrition related diseases and have a holistic growth.

SHYAMSUNDAR, K. G.(2003) states that Perfect nutrition can be achieved only through sufficient economics and education. Even if man acknowledges the primary significance of food in a living organism, they fail to understand its true essence and its role beyond the simple fuel providing metabolism. Proper nutrition is the only way to reduce the consumption of medications and speeds up the recovery of a human from a disease or an injury. The body has three energy systems which are used according to the needs of the body. The Adenosine Triphosphate – Phosphocreatine (ATP-PC) is the system that produces the maximum but short lived (6 seconds) that involves the production of ATP through the free phosphate from PC compound. The aerobic system generates ATP through breakdown of carbohydrates (Glycolysis) and fat (lipolysis). Although it cannot rapidly produce ATPs, it can generate large amount of energy. Glycogen – lactic acid system is activated during high intensity activity where the energy is depended on muscle glycogen. Increase in intensity of activity leads to gradual increase in dependency of muscle glycogen than fats. People Who involve in strenuous activity should be more focused on their diets for their wellbeing.

ALKERWI, A., SAUVAGEOT ET AL (2015) rationalizes that There is a close association between nutritional awareness and diet quality as indicated by energy density, dietary diversity, and adequacy. Cardiovascular diseases contribute to around 4 million deaths (49%). Even if obesity and chronic diseases contribute to most deaths, inappropriate dietary choices resulting in poor quality diet is emerging as a major modifiable factor. Increase in food availability at various locations and easy accessibility to processed and preserved food has a radical transformation of dietary patterns. Knowledge regarding diet and nutrition varies across geographical locations which further lies on cultural backgrounds, education etc. Awareness can be gained through one's own perceptions and also through the communication of information. Around 50% of the individual usually regard nutritional requirement as highly important. Higher proportion of women and people above the poverty line where aware about the significance of nutritional requirement. Participants who attached little importance to nutrition where usually younger and consumed less diverse foods and mainly consumed fatty foods.

FAST&UP, V. K. C. (2019) explains that Nutrition has the capability to not only be a deciding factor of an individual but rather the overall development of a country. Deficient awareness on Nutrition requirement leads to long term impact on health of an individual, leading to metabolism related disorders. This in turn leads to decreased productivity as the capacity of the person comes down leading to economic loss on macro level. Along with a proper diet, hydration plays a vital role. Water enriched with electrolytes are the best form to replenish the body's water level. vitamins are one of the crucial requirements for the development of the body. It must be noted that most Indians suffer from vitamin D, vitamin B12 vitamin B9 deficiency. Zinc and iron deficiency are also seen among most Indians.

MCNEILL, E., HASHEMI ET AL(2019). Interprets that Tailored health education is a new and unique concept in the field if culturally responsive care and eventually increases the effectiveness of the healthcare provided to that person. Taxi drivers are at risk for cancer, metabolic disease, hypertension, cardiovascular diseases because of long hours spent on driving. It is also due to their bad nutritional choices and continuous exposure to pollution. Their income also hinders them to reach out to more specific and responsive healthcare benefits. The article recommends the daily portions that includes 2 cups of fruits, 2 1/2 cups of vegetables, 2 1/2 cups of whole grain, 3cup of low-fat dietary, oil of 2 to 3 teaspoons a day and 2 portions of protein in size of palm.

MONTAZERIFAR, F., KARAJIBANI ET AL (2019) explains that Metabolic syndrome is a growing health problem in developing countries. Several factors contribute to this syndrome which includes genetic, metabolic, environmentally, and particularly jobs. Studies prove that the rate of ischemic heart diseases risk factors, including obesity, high blood glucose and higher triglycerides level among drivers are high than skilled workers. The metabolic syndrome was found to be in 20% ID the respondents our of which the tri glycerides, low high density lipoprotein cholesterol contributes to 81.4%. Hypertension with 28.8% was the least common component of metabolic diseases. Assessment of the physical activity shows that prevalence of metabolic syndrome was high among the group who did not have physical activity. Evaluation of food habits among the drivers that include high calorie food cooked in highly saturated oil, consisting of high amounts red meat and lower content of vegetables and fruits.

APPIAH, C. A., AFRIYIE ET AL (2020) describes that Commercial motor vehicle drivers are at risk of metabolic syndrome due to their occupational requirements such as long hours, irregular food habits and sleep patterns and live sedentary lifestyle. The prevalence of diabetes is around 12% among the drivers. They study shows that 63% of the respondents had hypertension. Obesity is the consequence of sedentary lifestyle in their profession with little to no physical activities. Around 32% were overweight and 12% suffered from obesity. Metabolic syndrome can be said as insulin resistance, deadly quartet, and syndrome X, which is a cluster of risk factors that increases the chance of heart diseases, stroke etc. It is checked through various risk factors insulin resistance, low level of high-density lipoprotein cholesterol, high triglycerides, hypertension, and obesity (large waist circumference).

KANNA, B., UKUDEYEVA ET AL (2020) rationalizes that The theme "poor diet " evolved from 151 related concepts from the respondents. All the participants perceived that they consume unhealthy diet due to eating high fatty meals at specific restaurants that offered food for lower prices The drivers find it difficult to have meal at proper time due to their long and irregular work hours. The drivers have also state about the poor quality of the food they consume. The theme " sedentary lifestyle " is derived from 147 concepts from the respondents. The economic factors demand them to work in average more than 10 hours per day. Even if they understand the importance of exercise, they are too tires that they would rather catch up on sleep. The theme " health nor a priority " was derived from 120 concepts of respondents where the taxi drivers prioritize their work and customer satisfaction than their health or well-being.

HAIDAR, A., KHOEI ET AL (2021). clarifies that Nutrients perform various functions of which being the basic component for cellular structure, the energy providing material are well known among humans. However, they play a major role in being signaling components, repressor and stimulator of gene expressions etc. the quality of nutrition is the major factor that influences the health of the individual. Single nutrient interventions such as salt with iodine has been the crucial in defeating disease such as goiter. Nutrition transition is the term used to understand the transformation of nutrition intake from being traditional to modern additional to the sedentary lifestyle of the upcoming generations. The increase in

acquired metabolic syndromes across the globe is mainly due to nutrition transition. It is very easily observed that the extrinsic factors and intrinsic factors are equally responsible for the overall nutrition of the individual. Consuming food that are low energy density and high nutrient diversity is the safest approach to a healthy lifestyle.

Mirpuri, S., Riley Et Al (2021) Elucidates that Occupational environment is a major reason for the well-being of the individual. Cab drivers tend to maximize their time of driving and hesitate to take breaks for health promoting activities such as taking a break, use restrooms regularly, eating lunch, stretching etc. Taxi drivers report suffering from sleep related issues including driver fatigue and sleep apnea. The obesity rates also have been at high in recent years. The comprehensive assessment to know about the nutritional requirement of cab drivers involves talking about the physical activity, diet nutrition, sleep quantity etc. Smoking participants particularly must be asked about the frequency of cigarette intake. Of the total 252 drivers who responded, 40% have not engaged in even a single physical activity in the recent times. The drivers reported low fruit and vegetable consumption. The average fruit consumption was 0.70 cups and average vegetable consumption was 1.82 cups. They also had an average sleep of 6.57 hours per night.

OK J. S., KANG, K ET AL (2022) states that Age plays a major factor in determining the healthy and nutritional lifestyle among cab drivers. There is a increase in the cognitive decline and Cardiovascular disorders among the age of 55-64 cab drivers. Driver obesity was more likely related to the decrease of physical health status. When looking from the economic aspect, a driver's income and the number of dependent family members also had a direct impact on decreasing physical well-being of the aged cab drivers. Taxi drivers do experience higher level of chronic knee and back pain when compared to the general population. The study hence shows that there is a decrease of physical health as the age of cab drivers increase. However, the middle age is considered to be more prone to illness as it is when the chronic condition start to develop.

WU, Y., WANG, S ET AL (2022). States that the knowledge about the nutritional requirement and content of your food play an important role in promoting healthy dietary behavior. The knowledge on nutrition can be assessed as four segments that include dietary guidelines, food and nutrition, nutrition and disease prevention, and nutrition skills. The total awareness rate among general population is around 20.4% with the highest (72.7%) about nutrition and disease prevention. Females tend to have more awareness about nutrition than men. The factors that determine this knowledge is age, gender, occupation, education level, residence area and history of chronic illness. the total awareness on nutrition is disappointing with more than three fourths of the respondents were unaware of the issue. Socio-demographic factors heavily influence the nutritional awareness.

BAKSHI, H. (2023) talks that in the recent times there is a flood of nutritional information, consumers are often confused and left with fears regarding their nutritional safety. While food in India is seen as only the component that chases away the hunger, it is actual significance for physical, mental, and social well-being are often overlooked. The global hunger index marks India at the bottom with child nutrition being the significant contributor. By raising awareness, perspectives related to the food and nutrition can be changed and better implementation of government projects can also be done. In India it is necessary to impart nutritional knowledge to dispel myth which in turns imparts good dietary habits. To achieve nutritional education at wider level, it is necessary to inculcate it at various starting from homes, schools, community centers etc. A good nutritional awareness will reward in a healthier population which in turn give out a productive population which helps to achieve a holistic well-being of the country

PRIYA, V. S. (2023) explains that Today's world has lead women and men to handle various

responsibilities including their careers. Proper nutrition will help them to maintain their work life balance and at the same time excel at both. Men typically need more calories intake than women due to their higher muscle mass and metabolic rate. A sedentary working man's calorie requirement would be around 2,200 to 2,800 calories per day. These numbers significantly increase in case of physically demanding professions. Protein is an important macronutrient which is required for muscle growth and repair. For working men 1.2 to 2.2 gram if protein per kilogram of body weight is recommended. Micronutrient deficiency is one major reason for tiredness in workplace. Men should focus on calcium levels for overall well-being. Mono-saturated and polyunsaturated fats helps to maintain good cardiovascular health. Men may need higher fat intake due to higher calorie requirement but must be in control to avoid high density lipoprotein cholesterol. Men should intake 25-38 grand of fiber per day to prevent various chronic diseases.

SEKGALA, M. D., OPPERMAN ET AL (2023). Illuminates that several epidemiological studies show that metabolic disease is high among the occupational drivers as compared to other professional. Most cab drivers are at risk of hypertension, myocardial infraction, hemorrhagic stroke. Most drivers have a habit of having one large meal a day and frequent snacks visits in between which are mostly oily and fried. They also majorly involve in alcohol and smoking to cope up with the high pressure in their profession. Consumption of this food combined with irregular sleep patterns and less physical exercise have increased the chances to 2.3 times to have abnormal high-density cholesterol. It also increases the chance of hypertension by 1.9 times.

RESEARCH METHODOLOGY

3.1 Title of the study:

A study on the perception and awareness of nutritional requirements in cab drivers.

3.2 Aim of the study:

To study the perception and awareness of nutritional requirements in cab drivers.

3.3 Objectives of the study:

1. To study the demographic profile of the cab drivers.
2. To inspect the perception and awareness of cab drivers on the significance of nutritional requirements.
3. To analyse the standard nutritional intake of cab drivers.

3.4 Statement of the problem:

The researcher has chosen the topic “A study on the perception and awareness of nutritional requirements in cab drivers.” Cab drivers play a crucial role in urban transportation systems, yet their health and well-being often receive limited attention. The study aims to address the overarching issue of the nutritional well-being of cab drivers, whose demanding work schedules and irregular eating habits may predispose them to nutritional deficiencies and health risks. Firstly, an exploration of the demographic profile of cab drivers will provide insights into their socio-economic backgrounds and potential factors influencing their dietary habits. Secondly, assessing the perception and awareness of cab drivers regarding the importance of nutritional requirements will shed light on any gaps in knowledge or misconceptions that may hinder their ability to make informed dietary choices.

Finally, an analysis of the standard nutritional intake of cab drivers will offer valuable information on their current dietary patterns and highlight areas for potential improvement or intervention to promote better health outcomes within this occupational group. By addressing these key objectives, this research aims to contribute to the development of targeted interventions and policies aimed at improving the nutritional health and overall well-being of cab drivers.

3.5 Scope of the study:

The scope of this research encompasses a comprehensive exploration of the perception and awareness of nutritional requirements among cab drivers, focusing on their demographic profile, understanding of nutritional significance, and dietary practices. The study will involve data collection from cab drivers operating in urban areas, with considerations for factors such as age, gender, years of experience, and working hours. While the research will primarily focus on cab drivers' perspectives and practices within a specific geographical area, the findings may offer insights applicable to similar occupational groups globally. The study's outcomes could inform targeted interventions aimed at promoting better nutrition and overall well-being among cab drivers, potentially yielding benefits for both their health and job performance.

3.6 Definition:

Conceptual Definition:

Nutrition: Nutrition as defined by Robinson (1982) is ' the science of foods and nutrients, their action, interaction and balance in relationship to health and disease, the processes by which the organism ingests, digests, absorbs, transports and utilizes nutrients and disposes of their end product'

Dietary Requirements: A dietary requirement is defined as the lowest continuing intake of a nutrient that for a specified indicator of adequacy, will maintain a defined level of nurturer in an individual.

Operational definition:

Malnutrition: Malnutrition is a grave condition arising from an inadequate intake of essential nutrients. It encompasses both undernutrition, which involves insufficient nutrient intake, and overnutrition, which entails an excess of nutrients beyond the body's requirements

3.7 Research design:

Research design is a blueprint, the framework in which the research takes place. The research design guides the way in which the research will progress. The researcher used descriptive research design. Descriptive research design is a type of research design that aims to systematically obtain information to describe a phenomenon, situation, or population. Researcher used this design to describe the perception and awareness of nutritional requirements in cab drivers.

3.8 Universe of the study:

Universe is the total population were the researcher gets the sample for the study. The universe of this study is Cab Drivers in South Tamil Nadu.

3.9 Sampling technique:

Sampling Technique are means or methods through which the data is being collected from the samples. The sampling technique used in the research is Purposive sampling. Purposive sampling involves selecting

participants based on specific criteria relevant to the research objectives. In this case, cab drivers are chosen deliberately due to their relevance to the study's focus on understanding the perception and awareness of nutritional requirements in this occupational group. Purposive sampling allows researchers to target participants who possess the characteristics or experiences of interest, thereby enhancing the relevance and depth of the data collected.

3.10 Source of data collection:

Primary data and secondary data are used in this research.

Primary data is the data obtained or collected directly. In this research, data were directly collected from samples.

Secondary data is the data obtained from other sources. Secondary data is collected from books, journals, articles, etc.

3.11 Tools of data collection:

The researcher employed a questionnaire as the primary instrument for data collection, comprising sections for demographic information alongside inquiries formulated by the researcher. These queries are designed to explore subjects pertaining to participants' nutritional awareness and dietary choices. The questionnaire serves as a tool to gather comprehensive data on the demographic profile of the respondents while also capturing insights into their understanding of nutrition and the dietary decisions they make.

3.12 Pre-test:

Pre testing is a method of verifying the tool of data collection and altering the tool based on the feedback given by the respondents. The pre-test was done with 5 respondents.

3.13 Limitation of the study:

- The study's reliance on a specific group of cab drivers within a particular geographic location may introduce sample bias, potentially limiting the applicability of the findings to other populations or regions.
- Due to the specific focus on cab drivers, the findings may not be easily generalizable to other occupational groups or individuals with different socioeconomic backgrounds.

3.14 CHAPTERISATION:

- Chapter I - Introduction
- Chapter II – Review of Literature
- Chapter III – Research Methodology
- Chapter IV – Data Analysis and Interpretation
- Chapter V – Findings, Suggestions and Conclusion
- Bibliography
- Questionnaire

DATA ANALYSIS AND INTERPRETATION

Table 4.1 Distribution of respondents based on Age

S.NO	Age Group	No of Respondents	Percentage
1.	18-25	7	14%
2.	26-35	22	44%
3.	36-45	16	32%
4.	46-55	5	10%
Total		50	100%

Table 4.1 shows most respondents fall within the age range of 26-35, comprising 44% of the total sample, followed by the 36-45 age group with 32%. Respondents aged 18-25 and 46-55 make up 14% and 10% of the sample, respectively.

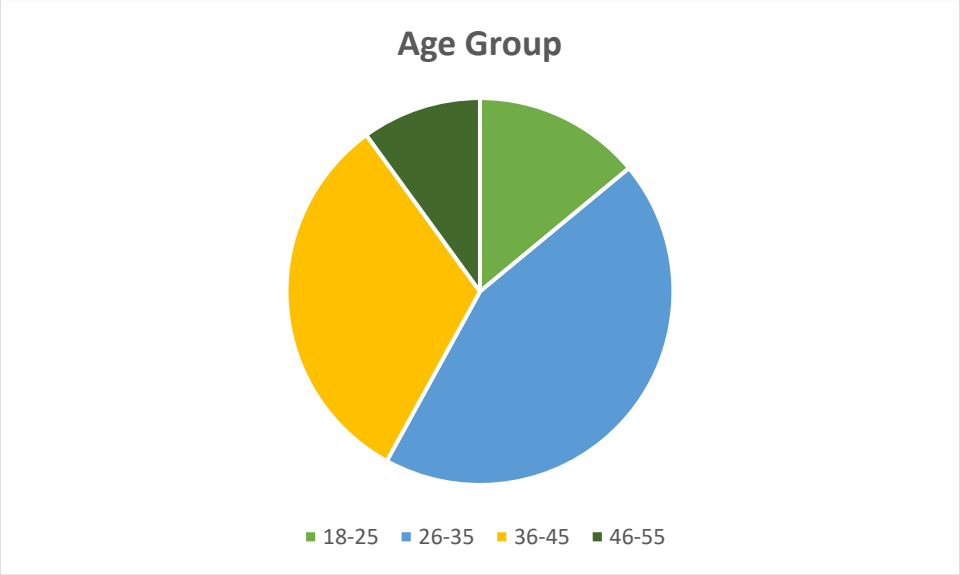

Figure 4.1

Table 4.2 Distribution of respondents based on Educational Qualification

S.NO	Educational Qualification	No of Respondents	Percentage
1.	Lack of Formal Education	1	2%
2.	6^{th}-10^{th} Std	15	30%
3.	11^{th}-12^{th} Std	13	26%
4.	Degree	21	42%
Total		50	100%

The table 4.2 presents the educational qualifications of respondents participating in the study. It indicates that the majority of respondents possess a degree (42%), followed by those with education up to the 6th-10th standard (30%) and 11th-12th standard (26%). A small percentage of respondents (2%) have reported a lack of formal education

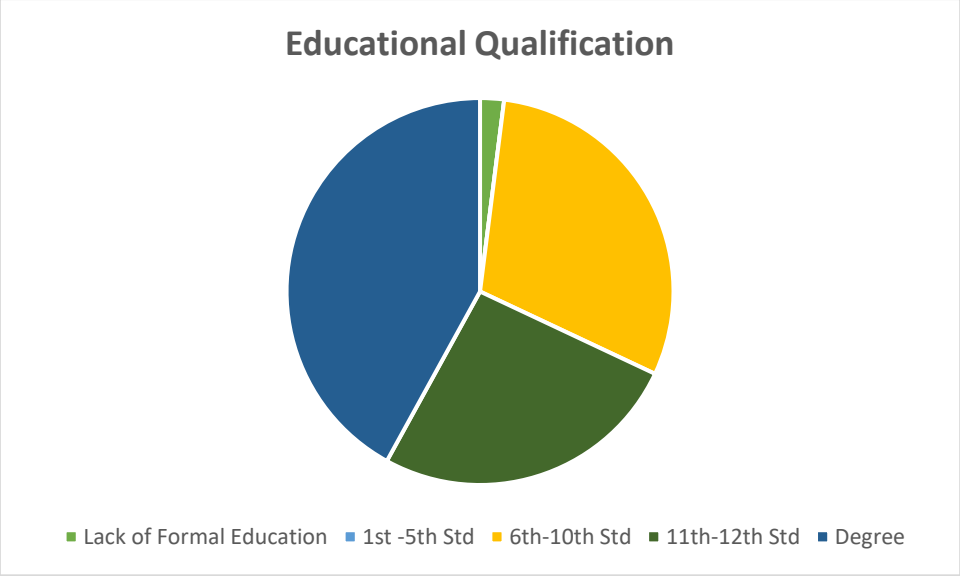

Figure 4.2

Table 4.3 Distribution of respondents based on Marital Status

S.NO	Marital Status	No of Respondents	Percentage
1.	Married	40	80%
2.	Single	10	20%
Total		50	100%

The table 4.3 provides a breakdown of the marital status of respondents in the study. The majority of respondents (80%) are married, while the remaining 20% are single.

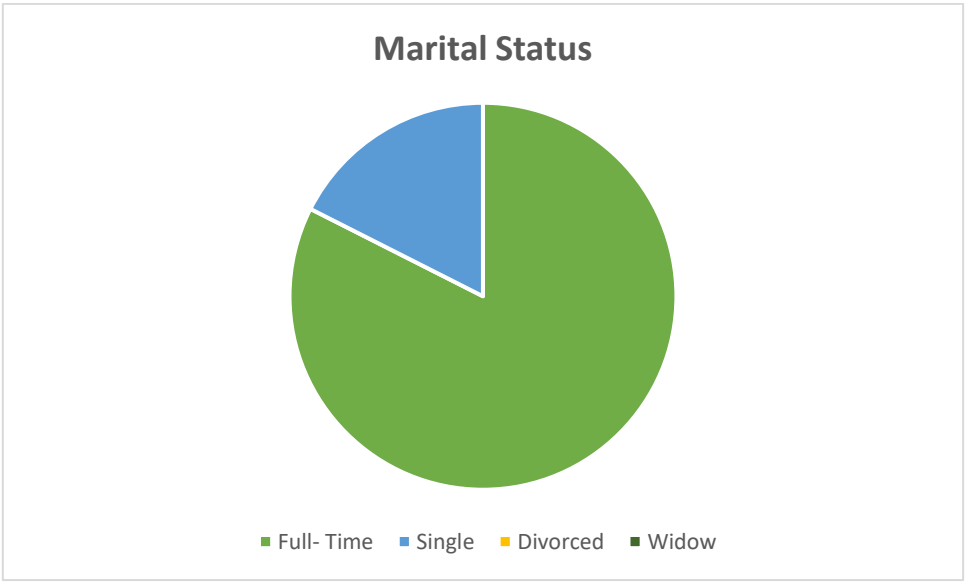

Figure 4.3

Table 4.4 Distribution of respondents based on Monthly Income

S.NO	Monthly Income	No of Respondents	Percentage
1.	Below 20,000	27	54%
2.	20,000 - 30,000	20	40%
3.	Above 30,000	3	6%
Total		50	100%

The table 4.4 presents the distribution of monthly income. The majority of respondents (54%) reported a monthly income below 20,000, followed by 40% with incomes ranging between 20,000 and 30,000. Only a small proportion (6%) reported earnings above 30,000 monthly.

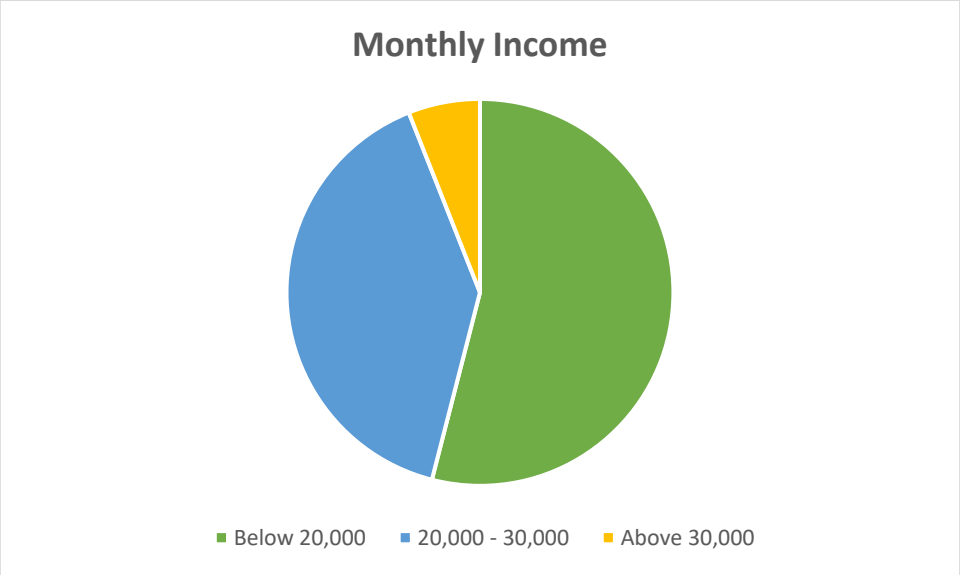

Figure 4.4

Table 4.5 Distribution of respondents based on Family Size

S.NO	Family Size	No of Respondents	Percentage
1.	2	1	2%
2.	3	14	28%
3.	4	22	44%
4.	5	9	18%
5.	6	4	8%
Total		50	100%

Table 4.5 presents the distribution of respondents based on family size. The majority of respondents have families comprising four members (44%), followed by families with three members (28%). Smaller proportions of respondents have families of five members (18%), six members (8%), and two members (2%).

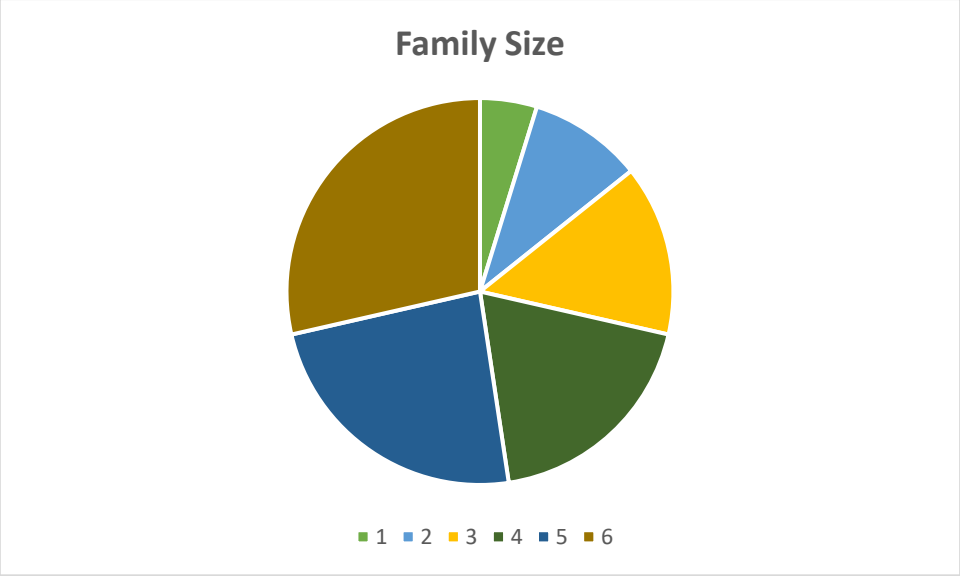

Figure 4.5

Table 4.6 Distribution of respondents based on Sole Provider of Family

S.NO	Sole Provider of the Family	No of Respondents	Percentage
1.	Yes	40	80%
2.	No	10	20%
Total		50	100%

Table 4.6 illustrates the distribution of respondents based on whether they are the sole provider of their family. Out of the total 50 respondents, 40 (80%) indicated that they are the sole providers, while 10 (20%) stated otherwise.

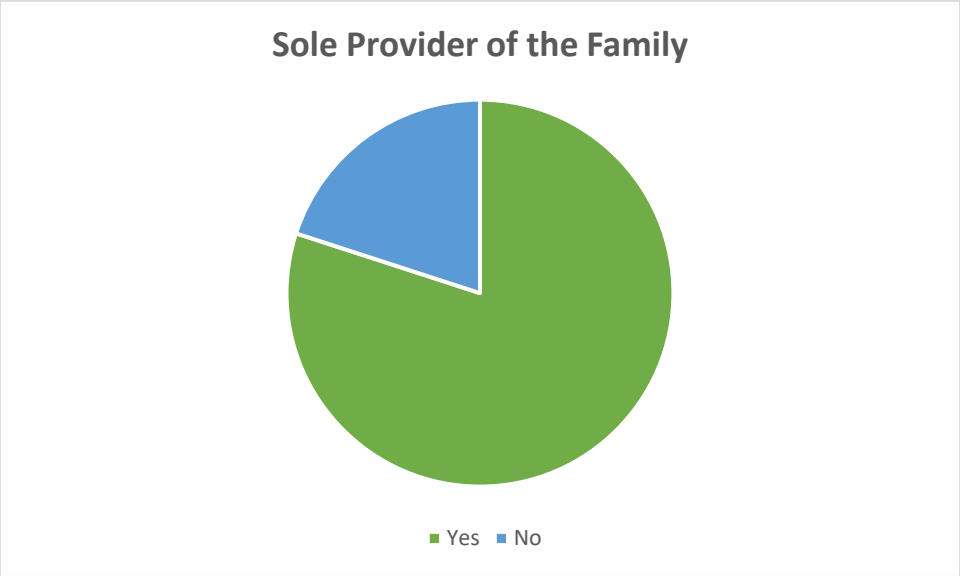

Figure 4.6

Table 4. 7 Distribution of respondents based on Part-Time vs. Full-Time

S.NO	Part-Time vs. Full-Time	No of Respondents	Percentage
1.	Part -Time	3	6%
2.	Full- Time	47	94%
Total		50	100%

Table 4.7 illustrates the distribution of respondents based on their employment status, distinguishing between part-time and full-time cab drivers. Out of the total 50 respondents, 3 (6%) are part-time drivers, while 47 (94%) are employed full-time.

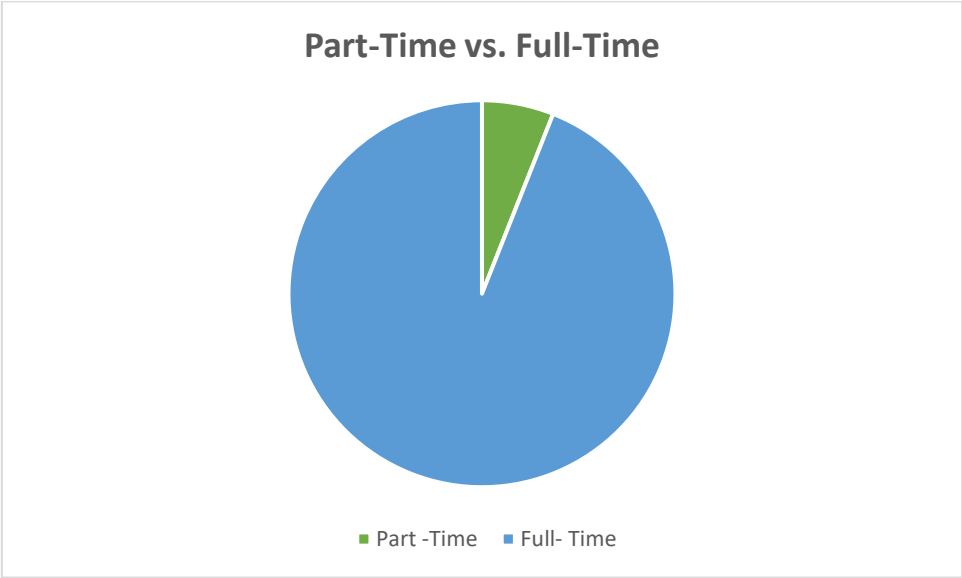

Figure 4.7

Table 4. 8 Distribution of respondents based on Professional Experience

S.NO	Professional Experience	No of Respondents	Percentage
1.	1-3 Years	7	14%
2.	4-6 Years	13	26%
3.	7-9 Years	9	18%
4.	9-12 Years	5	10%
5.	More than 12 Years	16	32%
Total		50	100%

Table 4.8 presents the distribution of respondents based on their professional experience. The majority of respondents have more than 12 years of experience, accounting for 32% of the total. This is followed by respondents with 4-6 years of experience, comprising 26%. Respondents with 7-9 years of experience represent 18%, while those with 1-3 years and 9-12 years of experience make up 14% and 10% respectively.

Figure 4.8

Table 4. 9 Distribution of respondents based on Working Hours

S.NO	Working Hours Per Day	No of Respondents	Percentage
1.	4-5 Hours	6	12%
2.	6-7 Hours	7	14%
3.	8-9 Hours	11	22%
4.	10 Hours and Above	26	52%
Total		50	100%

Table 4.9 presents the distribution of respondents based on their working hours. The majority of respondents, constituting 52%, reported working 10 hours or more per day. This is followed by 22% of respondents working 8-9 hours per day, while 14% reported working 6-7 hours per day, and 12% reported working 4-5 hours per day.

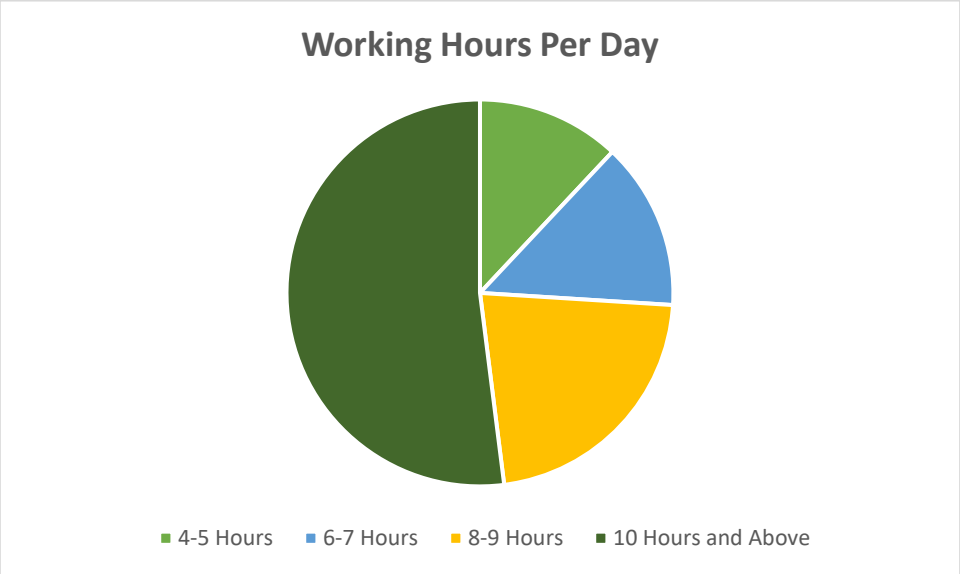

Figure 4.9

Table 4. 10 Distribution of respondents based on Working Schedule

S.NO	Working Schedule	No of Respondents	Percentage
1.	Day Shift	6	12%
2.	Night Shift	3	6%
3.	Irregular Shift	41	82%
Total		50	100%

The table 4.10 displays the distribution of respondents according to their working schedules. Among the 50 respondents surveyed, the majority, comprising 82%, reported having irregular shifts. Day shifts were reported by 12% of respondents, while 6% indicated working night shifts.

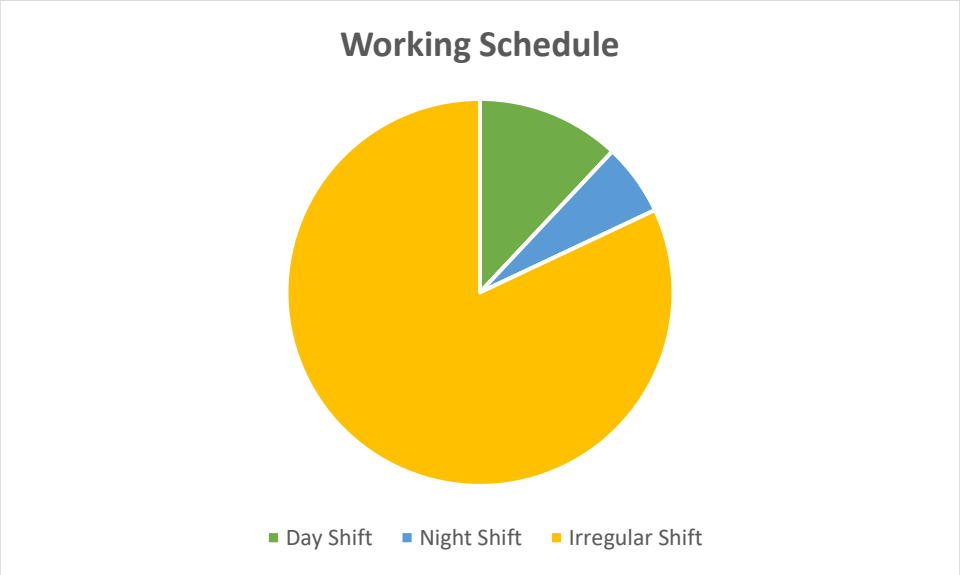

Figure 4.10

Table 4. 11 Distribution of respondents based on Physical Exercise

S.NO	Exercise Frequency	No of Respondents	Percentage
1.	Everyday	6	12%
2.	Weekly Once	8	16%
3.	Monthly once	25	50%
4.	Never	11	22%
Total		50	100%

The table 4.11 presents the distribution of respondents categorized by their frequency of physical exercise. Among the 50 respondents surveyed, the highest percentage (50%) reported exercising monthly, followed by 22% who indicated never exercising. Weekly exercise was reported by 16% of respondents, while 12% reported exercising daily.

Figure 4.11

Table 4. 12 Distribution of respondents based on Reason for skipping Physical Exercise

S.NO	Reason For Skipping Exercise	No of Respondents	Percentage
1.	Lack of Interest	5	10%
2.	Lack of Time	41	82%
3.	Not Recommended Medically	4	8%
Total		50	100%

Table 4.12 illustrates the distribution of respondents based on reasons for skipping physical exercise. Among the 50 respondents surveyed, the primary reason cited was "Lack of Time," accounting for 82% of responses. "Lack of Interest" was reported by 10% of respondents, while "Not Recommended Medically" constituted 8% of responses.

Figure 4.12

Table 4. 13 Distribution of respondents based on Nourishment Awareness

S.NO	Nourishment Awareness	No of Respondents	Percentage
1.	Yes	26	52%
2.	No	24	48%
Total		50	100%

Table 4.13 illustrates the distribution of respondents based on their level of nourishment awareness. Out of the total 50 respondents surveyed, 52% indicated awareness of nourishment, while 48% reported lacking awareness.

Figure 4.13

Table 4. 14 Distribution of respondents based on reason for Lack Nourishment Awareness

S.NO	Reason For Lack of Nourishment Awareness	No of Respondents	Percentage
1.	Lack of Interest	3	6%
2.	Lack of Time	24	48%
3.	Does not have Enough Knowledge Regarding it	23	46%
Total		50	100%

Table 4.14 presents the distribution of respondents based on reasons for lack of nourishment awareness. Of the 50 respondents surveyed, the majority (48%) cited lack of time as the primary reason, followed closely by 46% who reported not having enough knowledge regarding nourishment. Only 6% attributed their lack of awareness to a lack of interest.

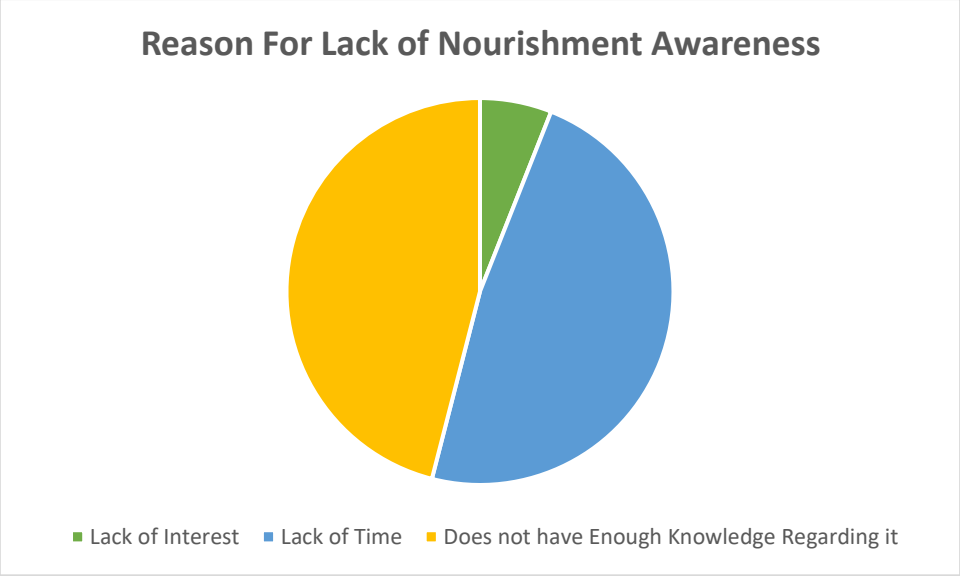

Figure 4.14

Table 4. 15 Distribution of respondents based on Major Carbohydrate in Diet

S.NO	Major Carbohydrate in Diet	No of Respondents	Percentage
1.	Rice	46	92%
2.	Wheat	4	8%
Total		50	100%

Table 4.15 illustrates the distribution of respondents based on the major carbohydrate in their diet. Among the 50 respondents surveyed, the overwhelming majority (92%) reported rice as their primary carbohydrate source, while only 8% indicated wheat as their main dietary carbohydrate.

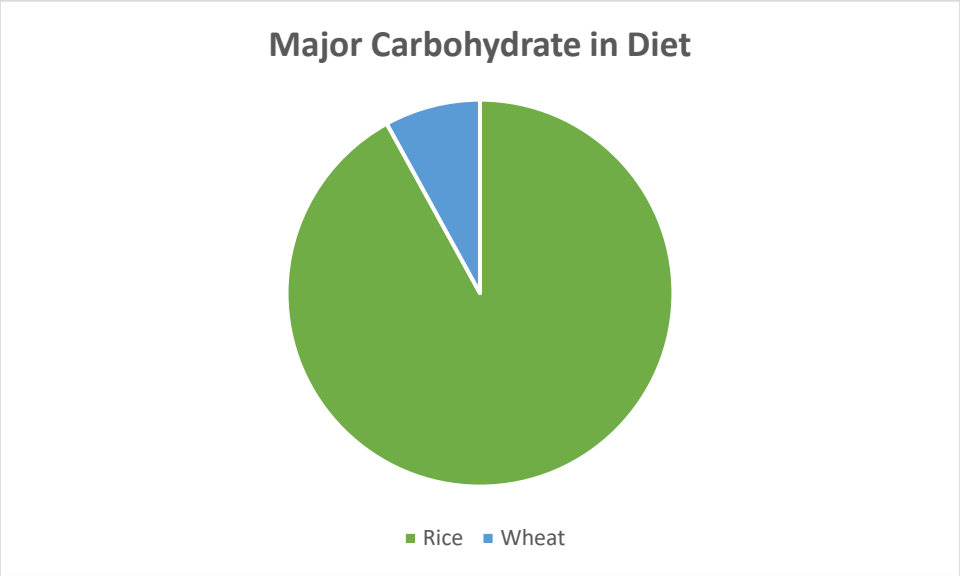

Figure 4.15

Table 4. 16 Distribution of respondents based on Meat Consumption Frequency

S.NO	Meat Consumption Frequency	No of Respondents	Percentage
1.	Everyday	7	14%
2.	Twice a Week	41	82%
3.	Vegetarian	2	4%
Total		50	100%

Table 4.16 showcases the distribution of respondents based on their meat consumption frequency. Among the 50 respondents surveyed, the majority (82%) reported consuming meat twice a week, followed by 14% who consumed meat every day. A small percentage (4%) identified as vegetarian.

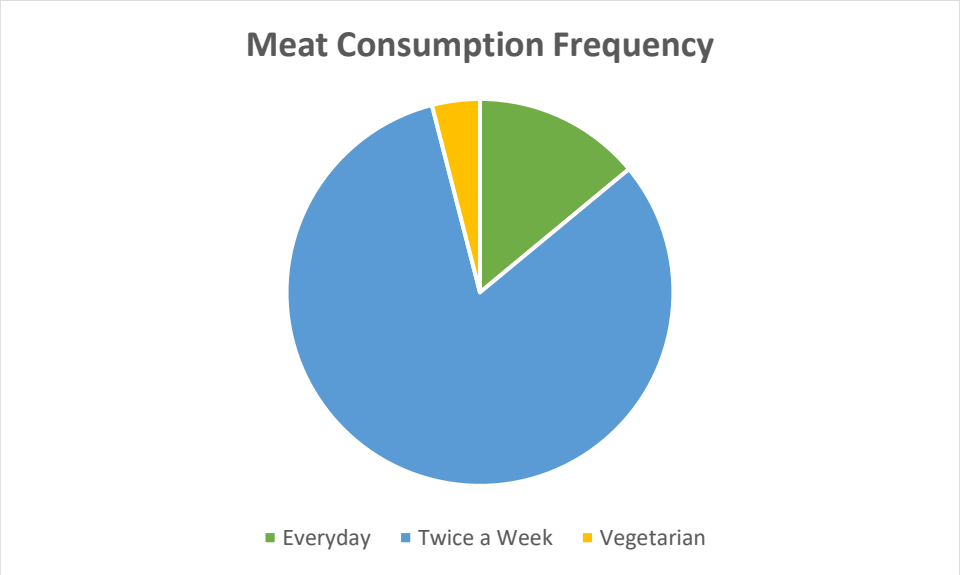

Figure 4.16

Table 4. 17 Distribution of respondents based on Everyday Fruit Consumption

S.NO	Everyday Fruit Consumption	No of Respondents	Percentage
1.	Yes	37	74%
2.	No	13	26%
Total		50	100%

Table 4.17 illustrates the distribution of respondents based on their everyday fruit consumption habits. Among the 50 respondents surveyed, the majority (74%) reported consuming fruits daily, while the remaining 26% indicated not consuming fruits daily.

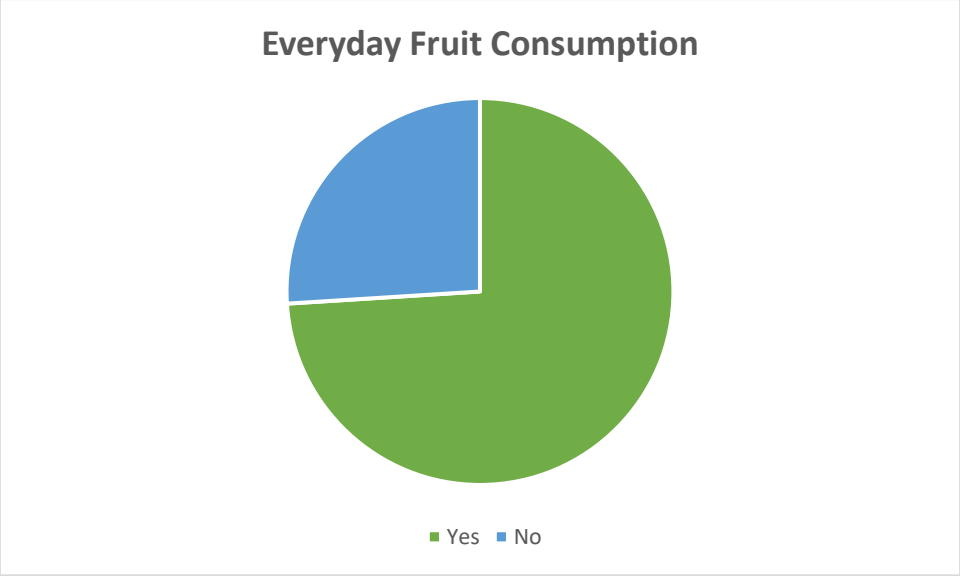

Figure 4.17

Table 4. 18 Distribution of respondents based on Reason for Avoiding Fruit Consumption

S.NO	Reason for Avoiding Fruit	No of Respondents	Percentage
1.	Expensive	25	50%
2.	Dislike Fruit Consumption	2	4%
3.	Lack of time	23	46%
Total		50	100%

Table 4.18 illustrates the distribution of respondents based on reasons for avoiding fruit consumption. Among the 50 participants surveyed, the most prevalent reason cited was the perceived expense of fruits, accounting for 50% of responses. Following closely, 46% of respondents reported avoiding fruit consumption due to a lack of time. A smaller percentage, 4%, expressed a dislike for consuming fruits as their reason for avoidance.

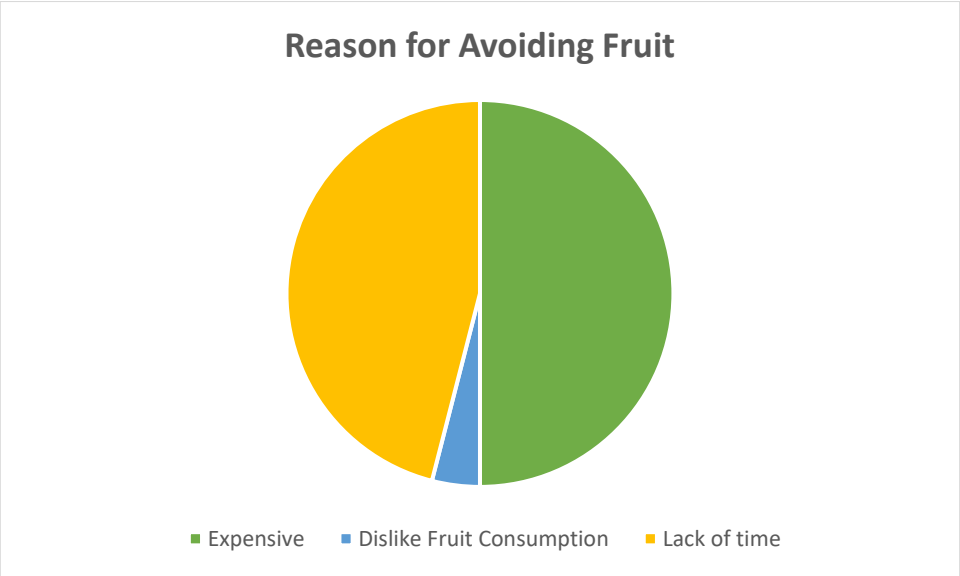

Figure 4.18

Table 4. 19 Distribution of respondents based on Major Caffeine

S.NO	Major Caffeine	No of Respondents	Percentage
1.	Tea	38	76%
2.	Coffee	10	20%
3.	Carbonated Drinks	2	4%
Total		50	100%

Table 4.19 illustrates the distribution of respondents based on their major sources of caffeine intake. Among the 50 respondents surveyed, the majority (76%) identified tea as their primary source of caffeine, followed by coffee, which was reported by 20% of respondents. Only a small percentage (4%) indicated carbonated drinks as their main source of caffeine.

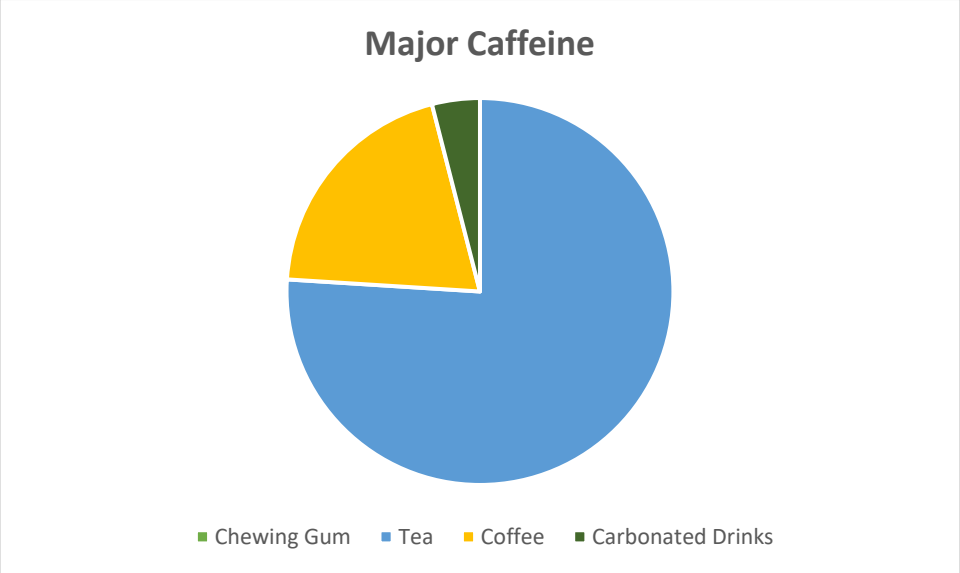

Figure 4. 19

Table 4. 20 Distribution of respondents based on Frequency of Caffeine Consumption

S.NO	Frequency of Caffeine Consumption	No of Respondents	Percentage
1.	Twice a Day	35	70%
2.	5 Times a Day	12	24%
3.	More than 5 Times	3	6%
Total		50	100%

Table 4.20 illustrates the distribution of respondents according to their frequency of caffeine consumption. Among the 50 respondents surveyed, the predominant pattern was consuming caffeine twice a day, with 70% reporting this frequency. Following this, 24% reported consuming caffeine five times a day, while a smaller proportion (6%) indicated consuming caffeine more than five times daily.

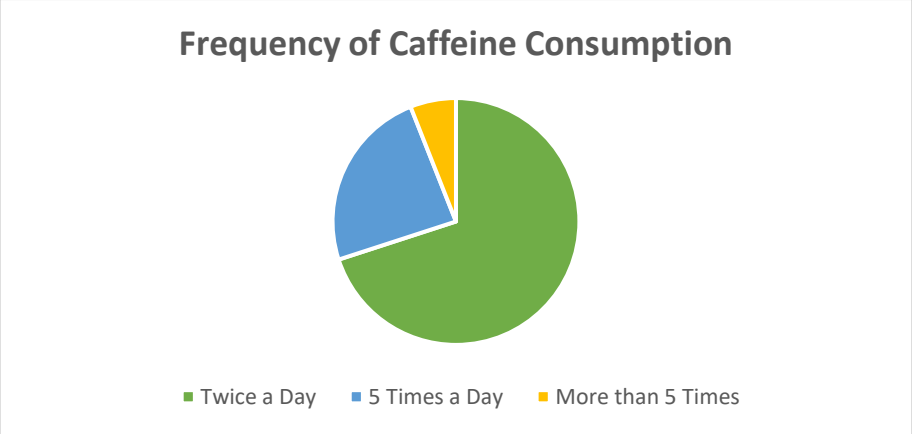

Figure 4. 20

Table 4. 21 Distribution of respondents based on Water Consumption Per Day

S.NO	Water Consumption Per Day (Litres)	No of Respondents	Percentage
1.	1	3	6%
2.	2	15	30%
3.	3	19	38%
4.	4	6	12%
5.	5	6	12%
6.	6	1	2%
Total		50	100%

Table 4.21 illustrates the distribution of respondents according to their daily water consumption in litres. Among the 50 respondents surveyed, the most prevalent category is 3 litres per day, accounting for 38% of the total. Following this, 30% reported consuming 2 litres daily, while both 4 and 5 litres per day were reported by 12% of respondents each. The least common reported intake is 6 litres per day, with only 2% of respondents indicating this amount.

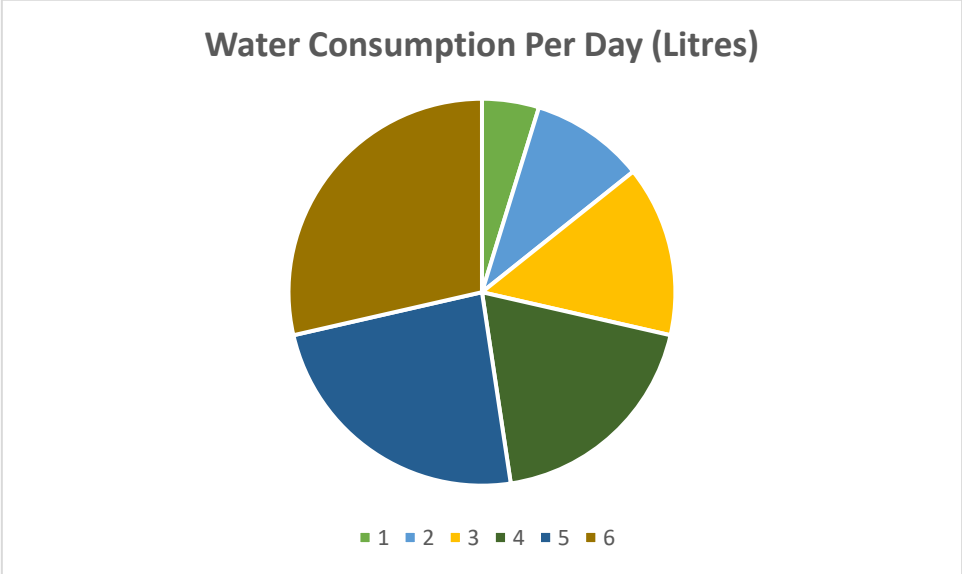

Figure 4.21

Table 4. 22 Distribution of respondents based on Frequency of Water Consumption

S.NO	Frequency of Water Consumption	No of Respondents	Percentage
1.	Every 1 Hours	15	30%
2.	Every 2 Hours	16	32%
3.	Every 3 Hours	10	20%
4.	More than 3 Hours	8	18%
Total		50	100%

Table 4.22 illustrates the distribution of respondents based on their frequency of water consumption per day. Among the 50 respondents surveyed, the highest percentage (32%) reported consuming water every 2 hours, closely followed by 30% who drank water every 1 hour. Twenty percent of respondents reported consuming water every 3 hours, while 18% indicated consuming water more than 3 hours apart.

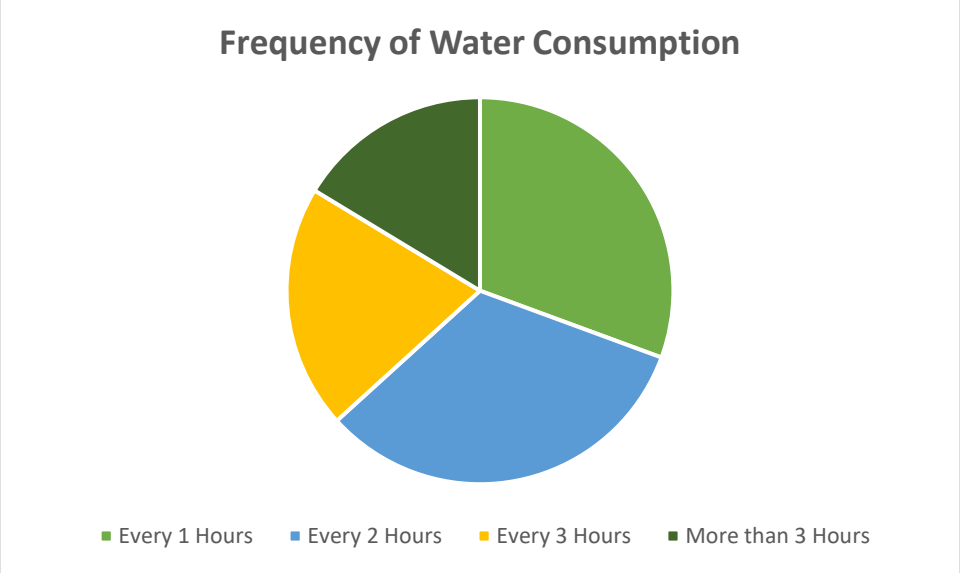

Figure 4.22

Table 4. 23 Distribution of respondents based on Frequency of Meals Per Day

S.NO	Frequency of Meals Per Day	No of Respondents	Percentage
1.	1 Meal	1	2%
2.	2 Meals	10	20%
3.	3 Meals	38	76%
4.	More than 3 Meals	1	2%
Total		50	100%

Table 4.23 illustrates the distribution of respondents based on the frequency of meals consumed per day. Among the 50 respondents surveyed, the majority (76%) reported consuming three meals daily, followed by 20% who consumed two meals per day. Only 2% reported having one meal or more than three meals per day, respectively.

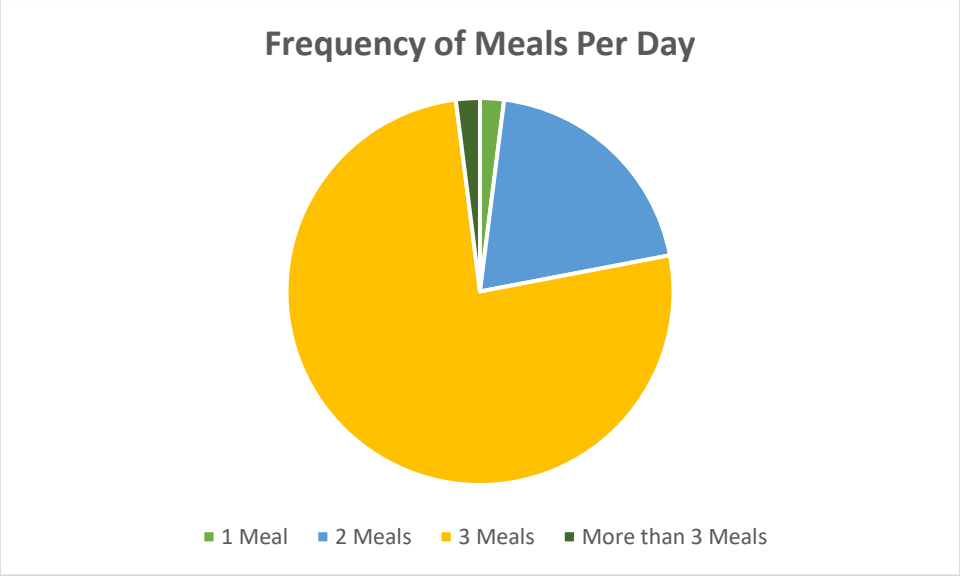

Figure 4.23

Table 4. 24 Distribution of respondents based on Reason for dietary Restriction

S.NO	Reason for dietary Restriction	No of Respondents	Percentage
1.	Allergy	4	8%
2.	Cultural Practices	21	42%
3.	Economic Challenges	25	50%
Total		50	100%

Table 4.24 illustrates the distribution of respondents based on reasons for dietary restriction. Among the 50 participants surveyed, economic challenges emerged as the most prevalent reason, accounting for 50% of responses. Cultural practices were cited by 42% of respondents, while allergies represented 8% of the reported reasons.

Figure 4.24

Table 4. 25 Distribution of respondents based Smoking Habit

S.NO	Smoking Habit	No of Respondents	Percentage
1.	Yes	13	26%
2.	No	37	74%
Total		50	100%

Table 4.25 illustrates the distribution of respondents based on their smoking habits. Among the 50 respondents surveyed, 74% reported not smoking, while 26% indicated that they did smoke.

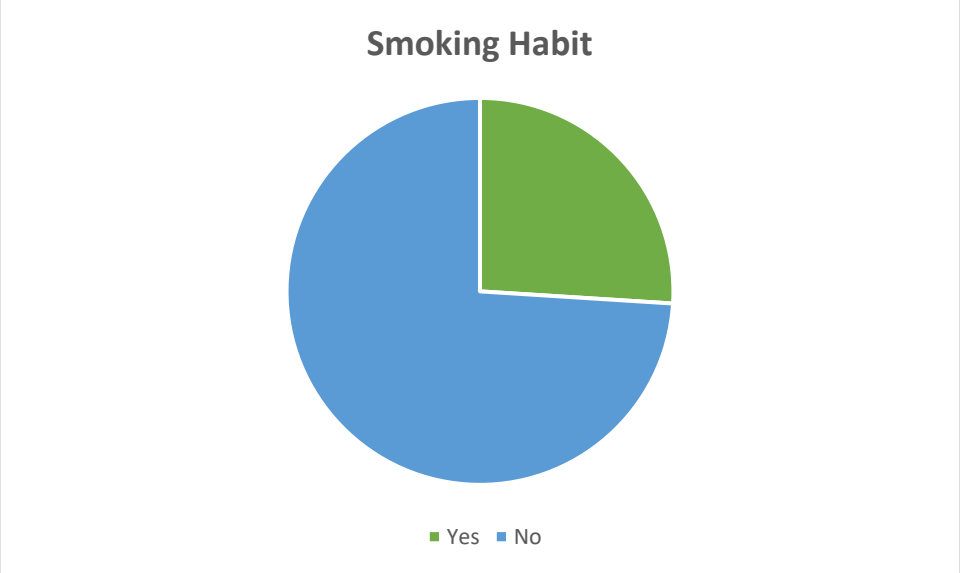

Figure 4.25

Table 4. 26 Distribution of respondents based on Frequency of Cigarette Per Day

S.NO	Frequency of Cigarette Per Day	No of Respondents	Percentage
1.	1	1	7.69%
2.	2	4	30.77%
3.	3	1	7.69%
4.	4	4	30.77%
5.	More than 4	3	23.08%
Total		13	100%

Table 4.26 illustrates the distribution of respondents based on the frequency of cigarette consumption per day. Among the 13 respondents surveyed, the most common frequency reported was consuming 2 cigarettes per day, accounting for 30.77% of respondents. This was followed by consuming 4 cigarettes per day, also at 30.77%. Additionally, 23.08% reported smoking more than 4 cigarettes daily, while both 1 and 3 cigarettes per day were each reported by 7.69% of respondents.

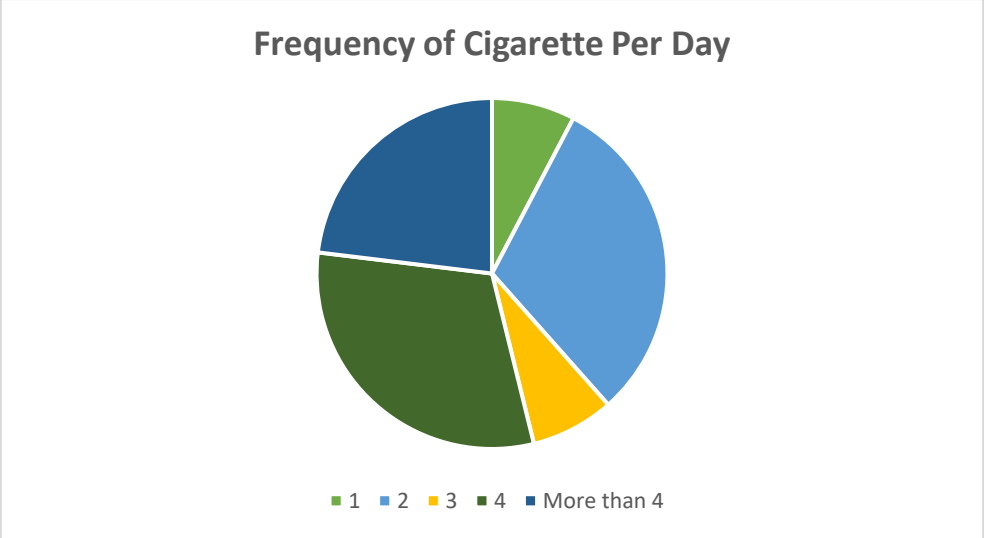

Figure 4.26

Table 4. 27 Distribution of respondents based on Frequency of Meals from Restaurant

S.NO	Frequency of Meals from Restaurant	No of Respondents	Percentage
1.	1 Meal	17	34%
2.	2 Meals	16	32%
3.	3 Meals	6	12%
4.	Never	12	24%
Total		50	100%

Table 4.27 illustrates the distribution of respondents based on the frequency of meals consumed from restaurants. Among the 50 participants surveyed, the most common frequency was one meal per day, accounting for 34%. Following closely, 32% reported consuming two meals from restaurants. A smaller proportion, 12%, opted for three meals, while 24% indicated never consuming meals from restaurants.

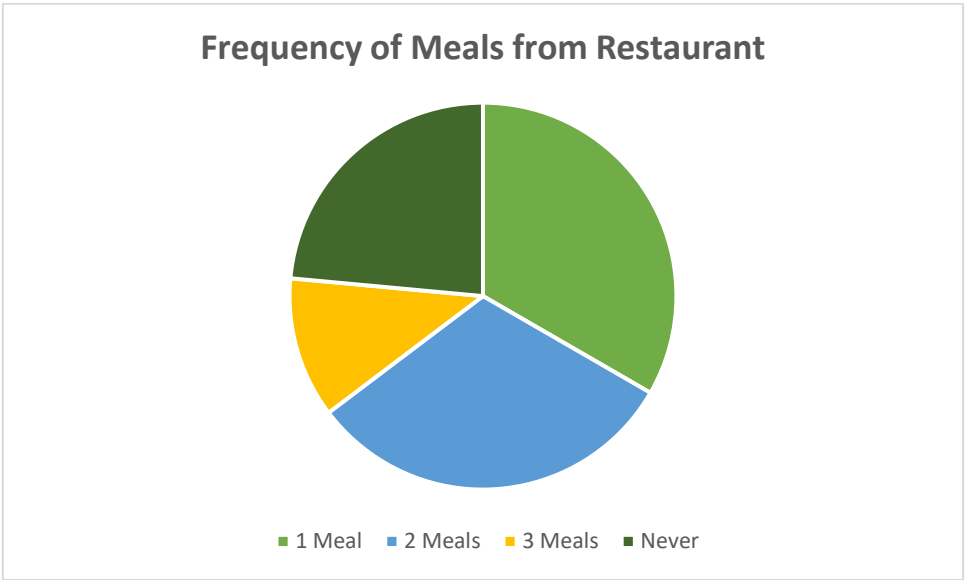

Figure 4.27

Table 4. 28 Distribution of respondents-based on Gap between Meals

S.NO	Gap between Meals	No of Respondents	Percentage
1.	3 Hours	8	16%
2.	4 Hours	13	26%
3.	5 Hours	17	34%
4.	6 Hours	3	6%
5.	More than 5 Hours	9	18%
Total		50	100%

Table 4.28 illustrates the distribution of respondents based on the gap between meals. Among the 50 respondents surveyed, the most common gap reported was 5 hours, constituting 34% of the sample. This was followed by a 4-hour gap, reported by 26% of respondents. A 3-hour gap was reported by 16% of respondents, while 6% reported a 6-hour gap. Additionally, 18% reported having a gap of more than 5 hours between meals.

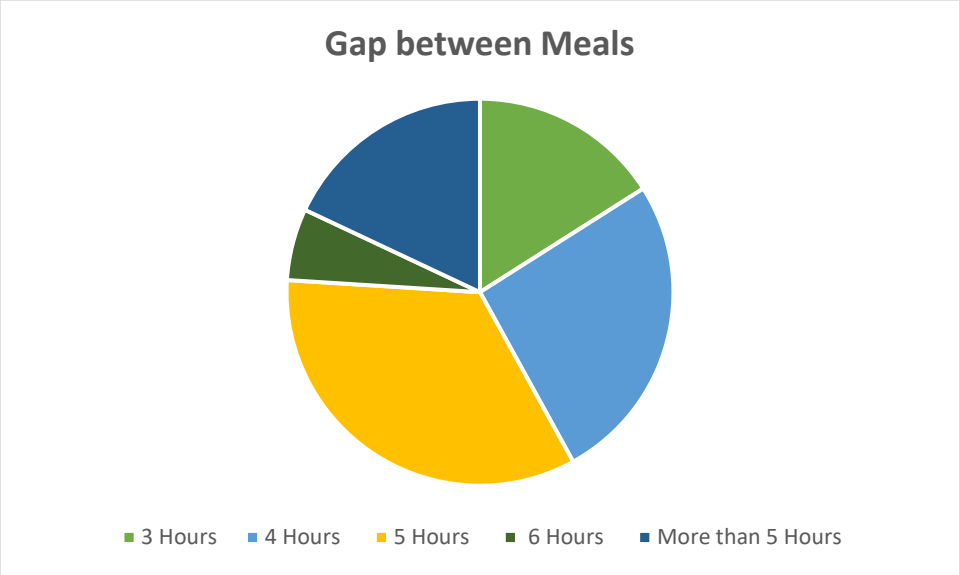

Figure 4.28

Table 4. 29 Distribution of respondents-based on Source of Nutritional Information

S.NO	Source of Nutritional Information	No of Respondents	Percentage
1.	Social media	35	70%
2.	Newspaper	2	4%
3.	Family	5	10%
4.	Peers	7	14%
5.	Physician	1	2%
Total		50	100%

Table 4.29 illustrates the distribution of respondents based on their primary sources of nutritional information. Among the 50 respondents surveyed, the majority (70%) reported obtaining nutritional

information from social media platforms. Peers accounted for 14% of respondents, while family members constituted 10%. A minimal percentage of respondents (4%) relied on newspapers for nutritional information, and only 2% sought guidance from physicians.

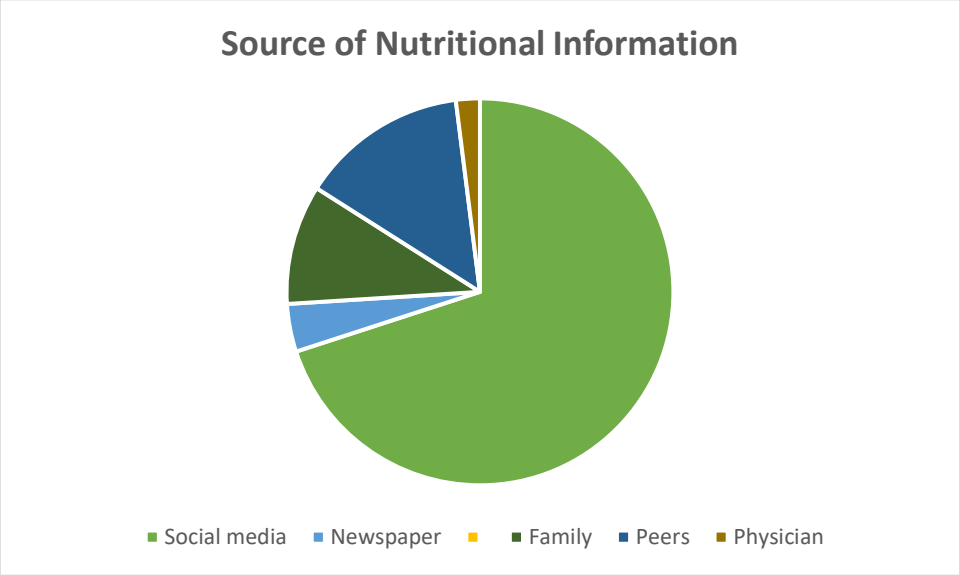

Figure 4.29

Table 4. 30 Distribution of respondents-based on Consumption of Snacks

S.NO	Consumption of Snacks	No of Respondents	Percentage
1.	Yes	34	68%
2.	No	16	32%
Total		50	100%

Table 4.30 illustrates the distribution of respondents based on their consumption of snacks. Among the 50 respondents surveyed, the majority (68%) reported consuming snacks, while 32% indicated they did not.

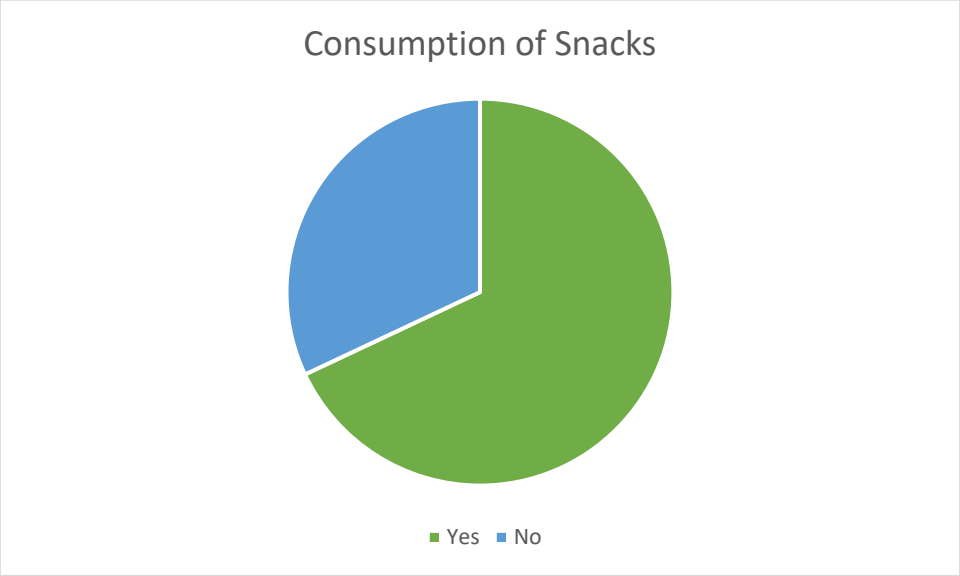

Figure 4.30

Table 4. 31 Distribution of respondents-based on Variety of snacks

S.NO	Variety of snacks	No of Respondents	Percentage
1.	Tea/ Coffee	22	44%
2.	Vadai/Baji/Samosa	17	34%
3.	Biscuit	2	4%
4.	Peanut	6	12%
5.	Fresh Juice/Buttermilk	3	6%
Total		50	100%

Table 4.31 illustrates the distribution of respondents based on the variety of snacks consumed. Among the 50 respondents surveyed, the most commonly consumed snacks were tea/coffee, accounting for 44% of respondents. Vadai/Baji/Samosa followed closely behind, with 34% of respondents indicating consumption. Peanuts were consumed by 12% of respondents, while fresh juice/buttermilk and biscuits were less popular choices, each accounting for 6% and 4% of respondents, respectively.

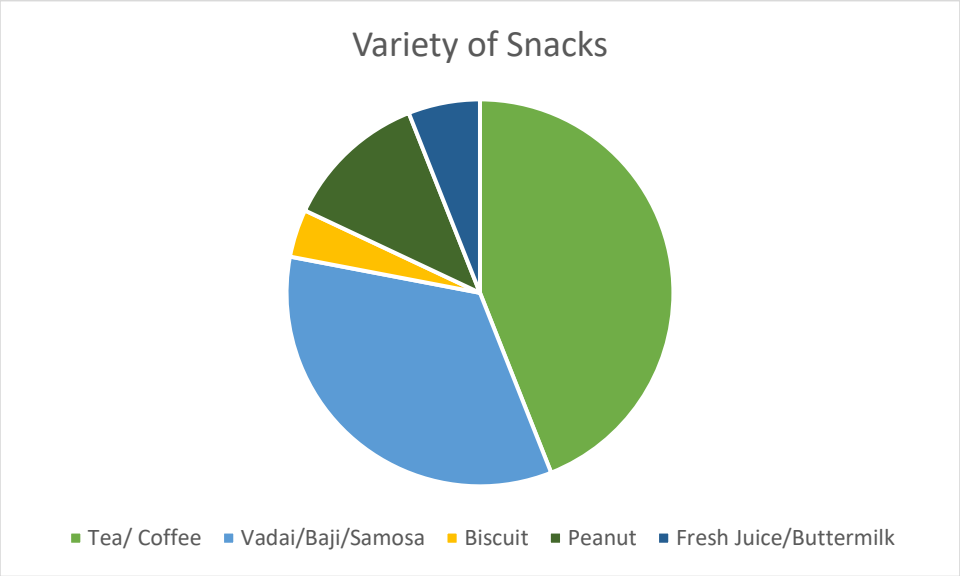

Figure 4.31

Table 4. 32 Distribution of respondents-based on Reason for your choice of Food

S.NO	Reason for your choice of Food	No of Respondents	Percentage
1.	Taste	15	30%
2.	Time	8	16%
3.	Health	7	14%
4.	Budget	15	30%
5.	Cultural Preferences	5	10%
Total		50	100%

Table 4.32 illustrates the distribution of respondents based on the reasons for their choice of food. Among the 50 participants surveyed, the most common reason cited was taste, accounting for 30% of responses. Budget considerations also played a significant role, with 30% of respondents indicating it as a deciding factor. Time constraints and health concerns each garnered 16% and 14% of responses, respectively. Cultural preferences were cited by 10% of respondents.

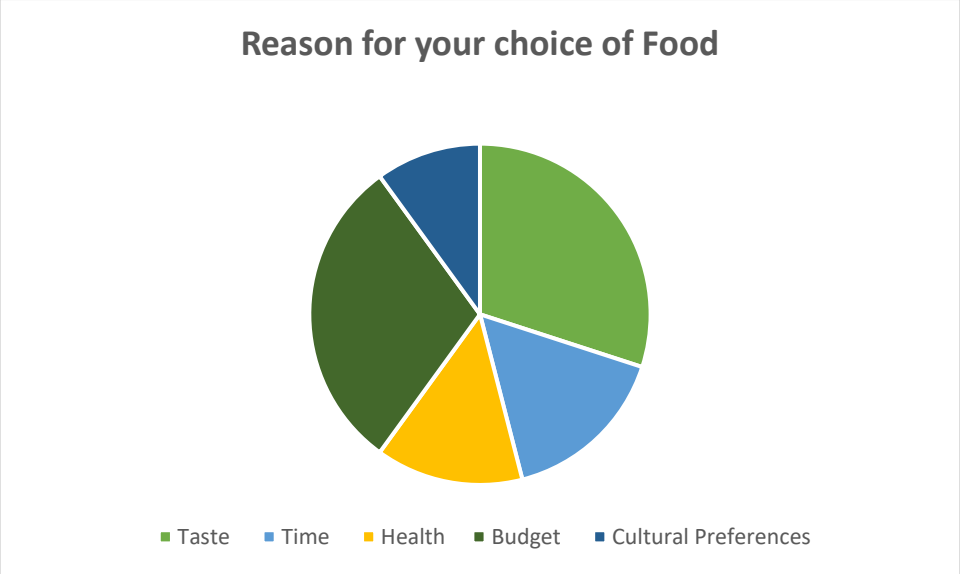

Figure 4.32

Table 4. 33 Distribution of respondents-based on Chronic Illness

S.NO	Chronic Illness	No of Respondents	Percentage
1.	Diabetes	0	0%
2.	Asthma	0	0%
3.	Heart Problems	2	4%
4.	Epilepsy	2	4%
5.	Absence of Chronic Illness	46	92%
Total		50	100%

Table 4.33 displays the distribution of respondents based on chronic illness. Among the 50 participants surveyed, the majority (92%) reported an absence of chronic illness. A small percentage of respondents indicated experiencing heart problems or epilepsy, each comprising 4% of the sample. No participants reported having diabetes or asthma.

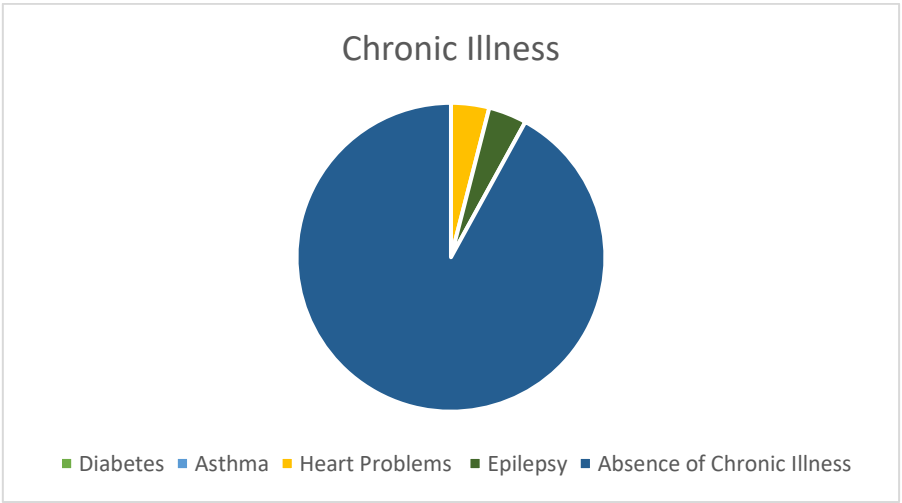

Figure 4.33

Table 4. 34 Distribution of respondents-based on Change in Dietary Habits for Health

S.NO	Change in Dietary Habits for Health	No of Respondents	Percentage
1.	Yes	7	14%
2.	No	43	86%
Total		50	100%

Table 4.34 displays the distribution of respondents based on their reported changes in dietary habits for health reasons. Among the 50 respondents surveyed, the majority (86%) indicated that they had not made any changes in their dietary habits for health purposes. In contrast, only 14% reported making changes to their dietary habits with the intention of improving their health.

Figure 4.34

Table 4. 35 Distribution of respondents-based on Purchase Priority

S.NO	Purchase Priority	No of Respondents	Percentage
1.	Price	32	64%
2.	Brand Name	6	12%
3.	Nutritional Information	12	24%
Total		50	100%

Table 4.35 showcases the distribution of respondents based on their purchase priorities. Among the 50 respondents surveyed, the majority (64%) prioritize price when making purchasing decisions. Following closely, 24% consider nutritional information as their primary purchase priority, while only 12% prioritize brand name.

Figure 4.35

Table 4. 36 Distribution of respondents-based on Experience of Poor Nutrition Impact in Body

S.NO	Experience of Poor Nutrition Impact in Body	No of Respondents	Percentage
1.	Yes	33	66%
2.	No	17	24%
Total		50	100%

Table 4.36 illustrates the distribution of respondents based on their experience of poor nutrition impacting their bodies. Among the 50 participants surveyed, a significant majority (66%) reported experiencing adverse effects of poor nutrition on their bodies. Conversely, 34% of respondents indicated not experiencing such impacts.

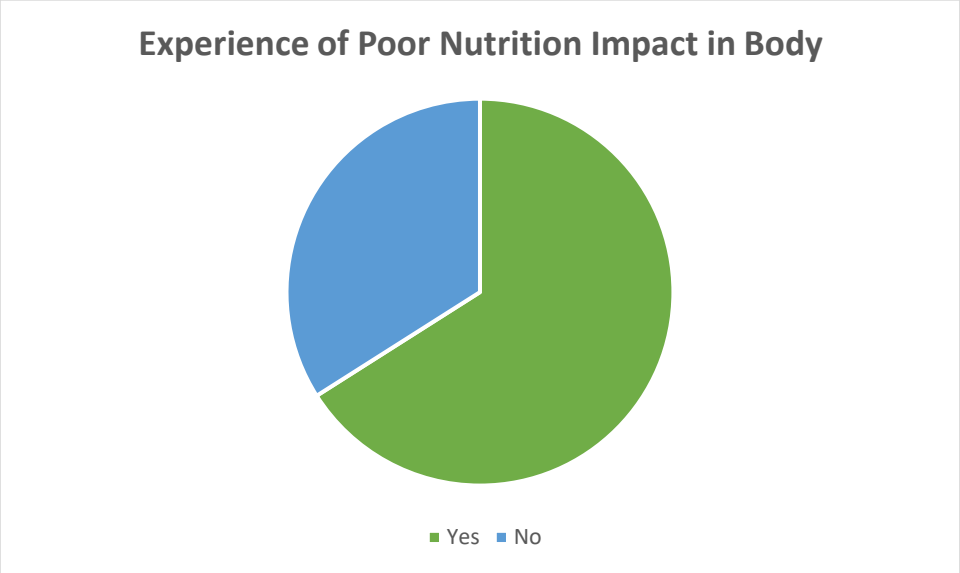

Figure 4.36

Table 4. 37 Distribution of respondents-based on Reason for Nutritional Neglect

S.NO	Reason for Nutritional Neglect	No of Respondents	Percentage
1.	Financial Situation	17	34%
2.	Profession	24	48%
3.	Lack of Knowledge	9	18%
Total		50	100%

Table 4.37 illustrates the distribution of respondents based on reasons for nutritional neglect. Among the 50 participants surveyed, the most frequently cited reason was profession, with 48% attributing their nutritional neglect to their occupation. Financial situation followed closely behind, accounting for 34% of responses. Lack of knowledge was mentioned by 18% of respondents as a reason for nutritional neglect.

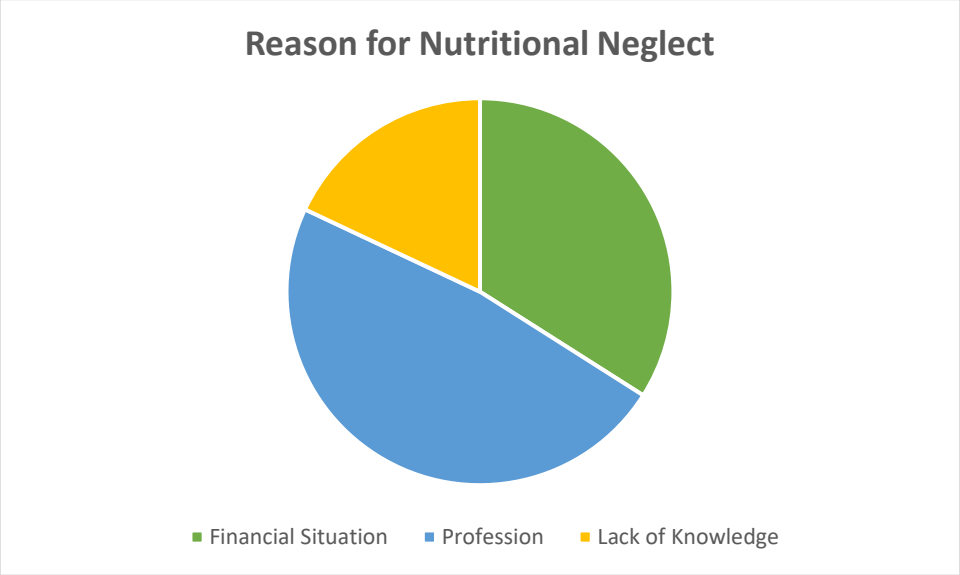

Figure 4.37

Table 4. 38 Distribution of respondents-based on Awareness on Nutritional Trends

S.NO	Awareness on Nutritional Trends	No of Respondents	Percentage
1.	Yes	14	28%
2.	No	36	72%
Total		50	100%

Table 4.38 illustrates the distribution of respondents based on their awareness of nutritional trends. Among the 50 respondents surveyed, the majority (72%) reported not being aware of nutritional trends, while 28% indicated they were aware.

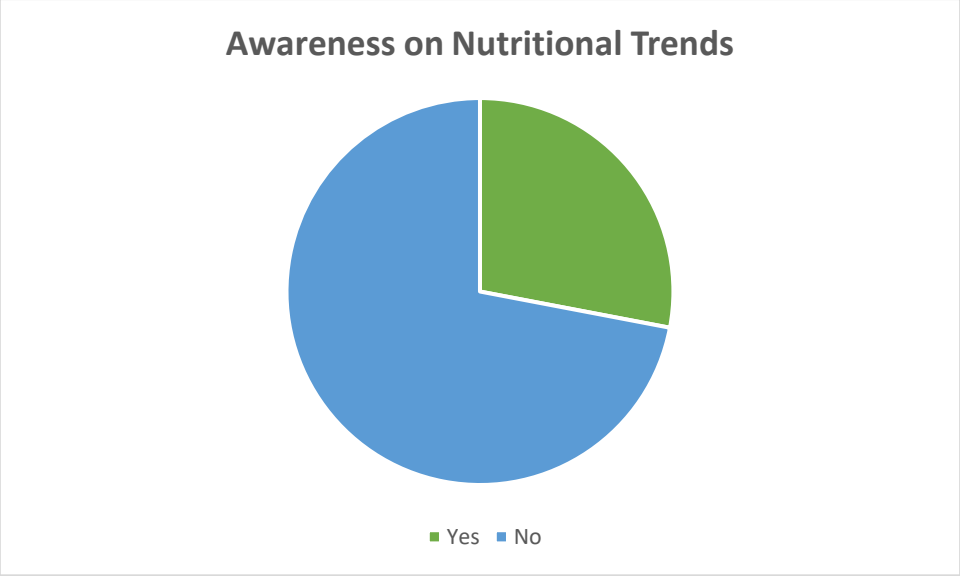

Figure 4.38

Table 4. 39 Distribution of respondents-based on Interest in Nutritional Trends

S.NO	Interest in Nutritional Trends	No of Respondents	Percentage
1.	Yes	15	30%
2.	No	35	70%
Total		50	100%

Table 4.39 illustrates the distribution of respondents based on their interest in nutritional trends. Among the 50 participants surveyed, the majority (70%) indicated they were not interested in nutritional trends, while 30% expressed interest in them.

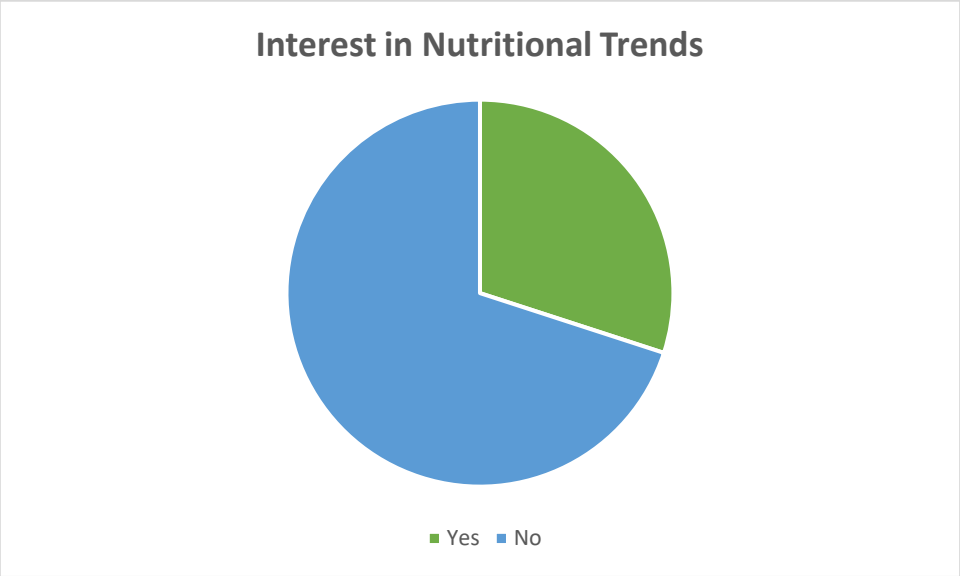

Figure 4.39

Table 4. 40 Distribution of respondents-based on Awareness on Government Nutritional Schemes

S.NO	Awareness on Government Nutritional Schemes	No of Respondents	Percentage
1.	Yes	11	22%
2.	No	39	78%
Total		50	100%

Table 4.40 illustrates the distribution of respondents based on their awareness of government nutritional schemes. Among the 50 respondents surveyed, the majority (78%) reported not being aware of any government nutritional schemes, while only 22% indicated awareness of such programs.

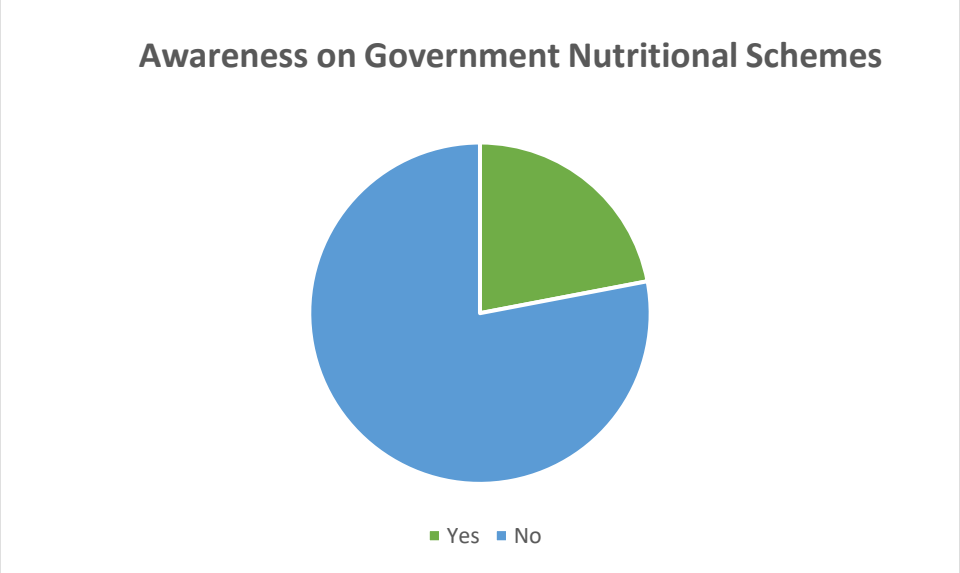

Figure 4.40

Table 4. 41 Distribution of respondents-based on Beneficiaries Nutritional Government Schemes

S.NO	Beneficiaries Nutritional Government Schemes	No of Respondents	Percentage
1.	Yes	6	54.55%
2.	No	5	45.45%
Total		11	100%

Table 4.41 illustrates the distribution of respondents based on their participation in government nutritional schemes. Among the 11 respondents surveyed, 54.55% indicated being beneficiaries of such schemes, while 45.45% reported not benefiting from them.

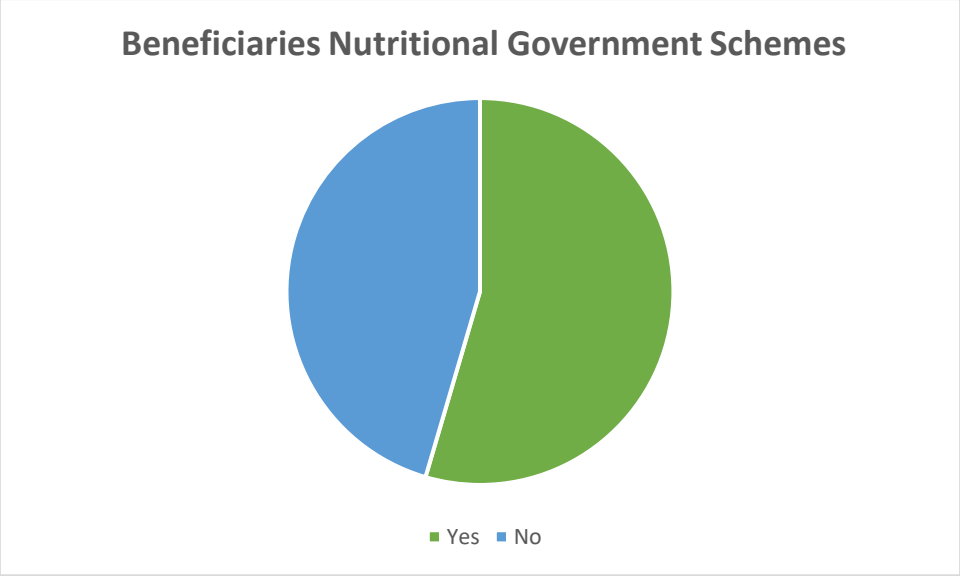

Figure 4.41

Table 4. 42 Distribution of respondents-based on Need for Nutritional Awareness in Society and Schools

S.NO	Need for Nutritional Awareness in Society and Schools	No of Respondents	Percentage
1.	Yes	44	88%
2.	No	6	12%
Total		50	100%

Table 4.42 illustrates the distribution of respondents based on the perceived need for nutritional awareness in society and schools. Among the 50 respondents surveyed, a vast majority (88%) acknowledged the necessity for nutritional awareness initiatives in both society and schools. Only 12% of respondents indicated otherwise, suggesting a lower priority for such programs.

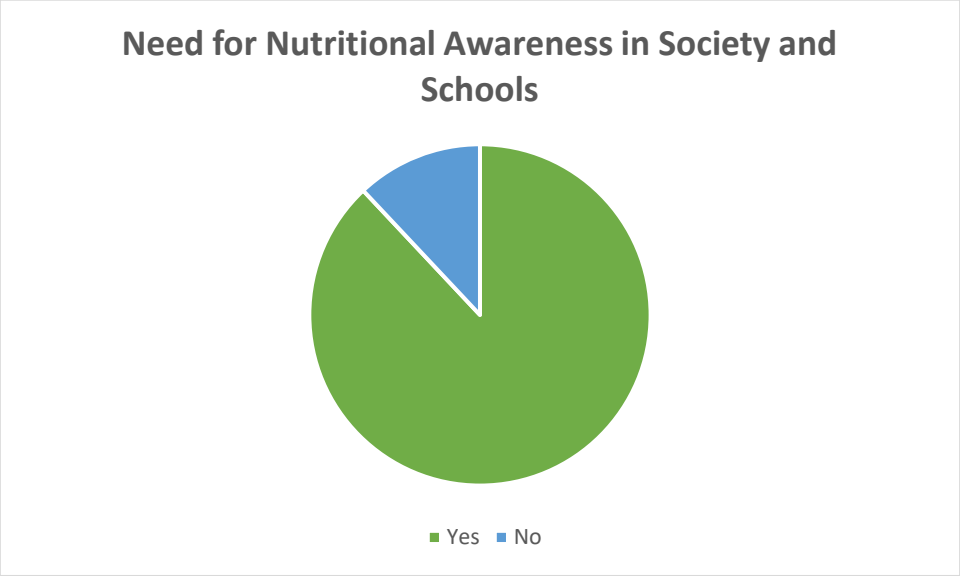

Figure 4.42

Table 4.43 Distribution of respondents-based on Sleep Duration

S.NO	Sleep Duration	No of Respondents	Percentage
1.	5 Hours	8	16%
2.	6 Hours	16	32%
3.	7 Hours	14	28%
4.	8 Hours	12	24%
5.	9 Hours	9	18%
6.	10 Hours	1	2%
Total		50	100%

Table 4.43 illustrates the distribution of respondents based on their sleep duration. Among the 50 participants surveyed, the most common sleep duration reported was 6 hours, constituting 32% of the respondents. This was followed by 7 hours (28%), 8 hours (24%), 5 hours (16%), and 9 hours (18%). Only 2% reported a sleep duration of 10 hours.

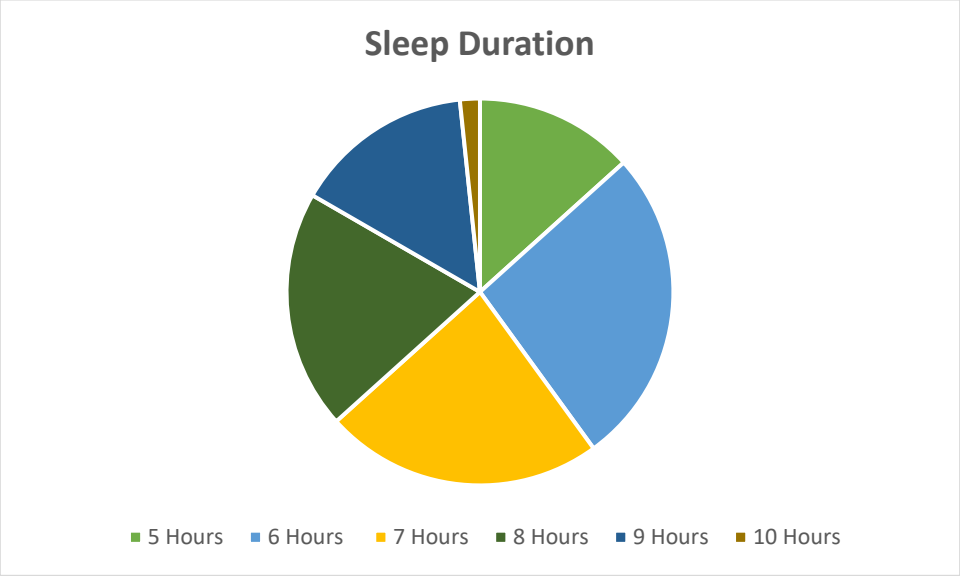

Figure 4.43

Table 4.44 Distribution of respondents-based on Perspective on Supplements

S.NO	Perspective on Supplements	No of Respondents	Percentage
1.	Positive	17	34%
2.	Negative	5	10%
3.	Neutral	13	26%
4.	Insufficient Data	15	30%
Total		50	100%

Table 4.44 displays the distribution of respondents based on their perspectives on supplements. Among the 50 respondents surveyed, the highest percentage (34%) held a positive perspective on supplements, followed by 30% who felt there was insufficient data. A notable 26% remained neutral, while only 10% expressed a negative viewpoint.

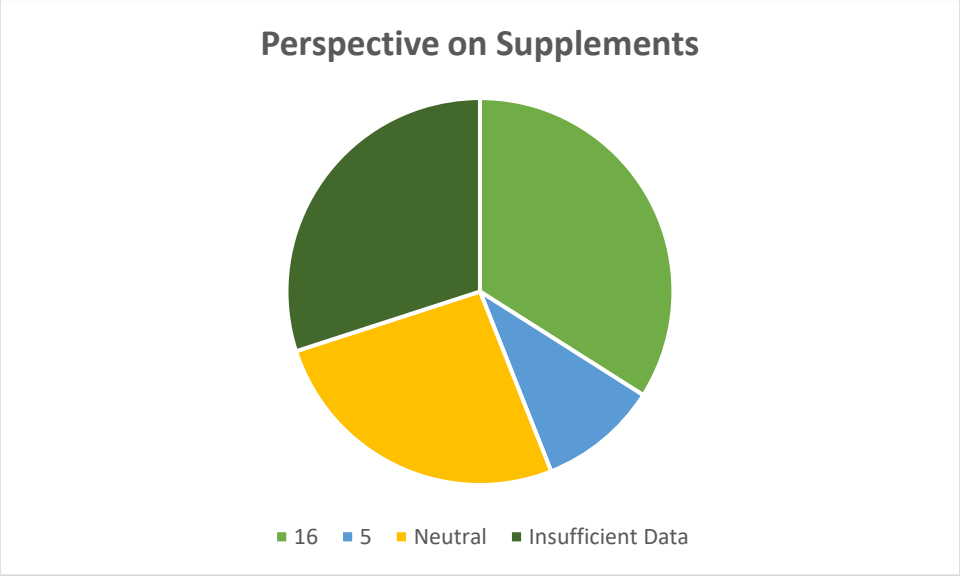

Figure 4.44

Table 4. 45 Distribution of respondents-based on Activities to avoid Tiredness

S.NO	Activities to avoid Tiredness	No of Respondents	Percentage
1.	Consumption of Caffeine	25	50%
2.	Short Nap	12	24%
3.	Breathing Exercise	5	10%
4.	Listening to Radio	8	16%
Total		50	100%

Table 4.45 illustrates the distribution of respondents based on activities to avoid tiredness. Among the 50 respondents surveyed, the most common activity reported was the consumption of caffeine, with 50% of respondents endorsing it. Following this, 24% of respondents preferred taking short naps, while 16% reported listening to the radio. Only 10% of respondents mentioned engaging in breathing exercises.

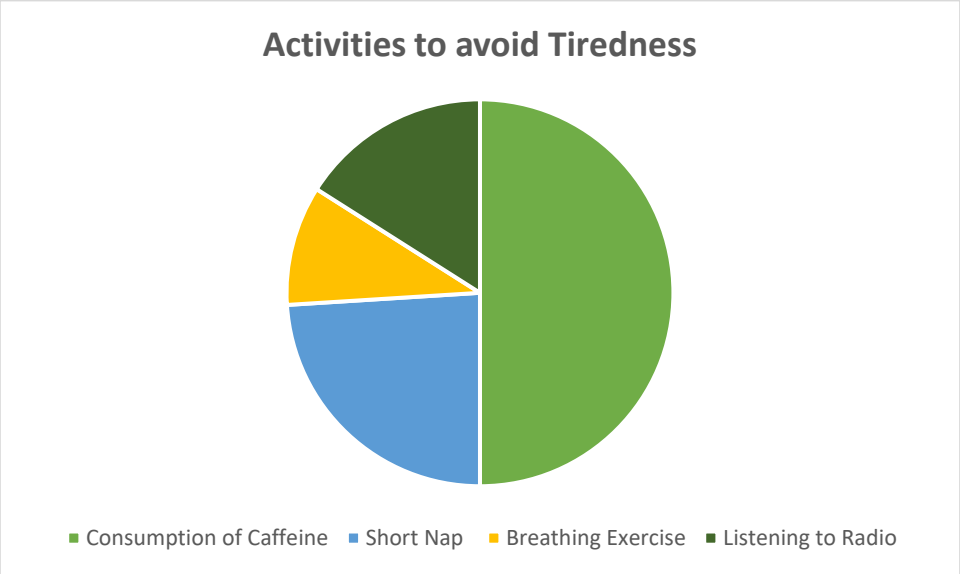

Figure 4.45

Table 4. 46 Distribution of respondents-based on Role of Cab Companies in Promoting Nutrition

S.NO	Role of Cab Companies in Promoting Nutrition	No of Respondents	Percentage
1.	Food Alert Messages	10	20%
2.	Provide Nutritional Supplements	25	50%
3.	Mandatory Breaks	7	14%
4.	Do not play a role	8	16%
Total		50	100%

Table 4.46 illustrates the distribution of respondents based on the perceived role of cab companies in promoting nutrition. Among the 50 respondents surveyed, the majority (50%) indicated that cab companies provide nutritional supplements as part of their role. Following closely, 20% mentioned receiving food alert messages from their companies, while 14% noted the implementation of mandatory breaks. A smaller percentage (16%) felt that cab companies do not play a role in promoting nutrition.

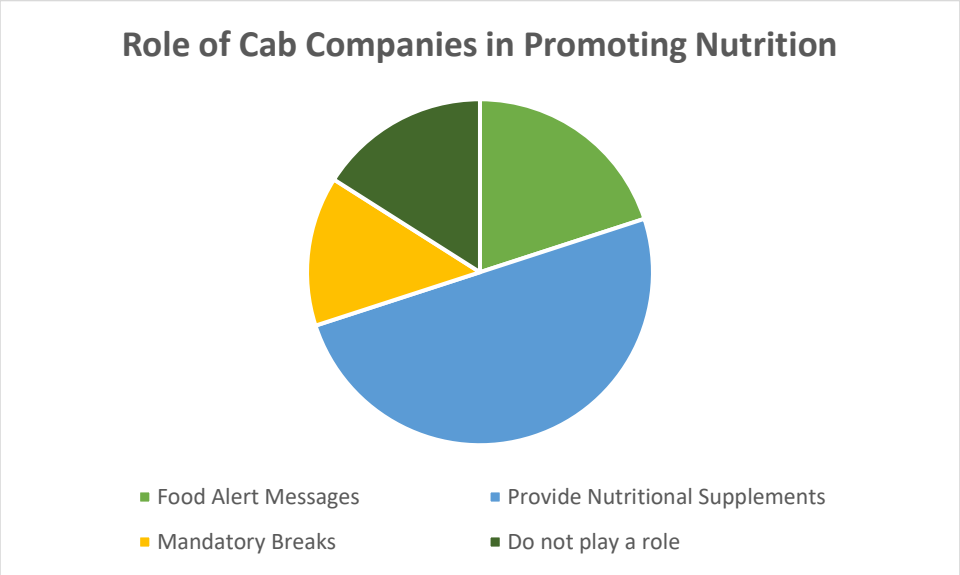

Figure 4.46

Table 4.47 Distribution of respondents-based on Recent Changes in Dietary Habits for Better Nutrition

S.NO	Recent Changes in Dietary Habits for Better Nutrition	No of Respondents	Percentage
1.	Yes	44	88%
2.	No	6	12%
Total		11	100%

Table 4.47 illustrates the distribution of respondents based on recent changes in dietary habits for better nutrition. Among the 50 respondents surveyed, a significant majority (88%) reported making recent changes in their dietary habits to enhance nutrition. Only a small portion (12%) indicated no recent changes in their dietary habits.

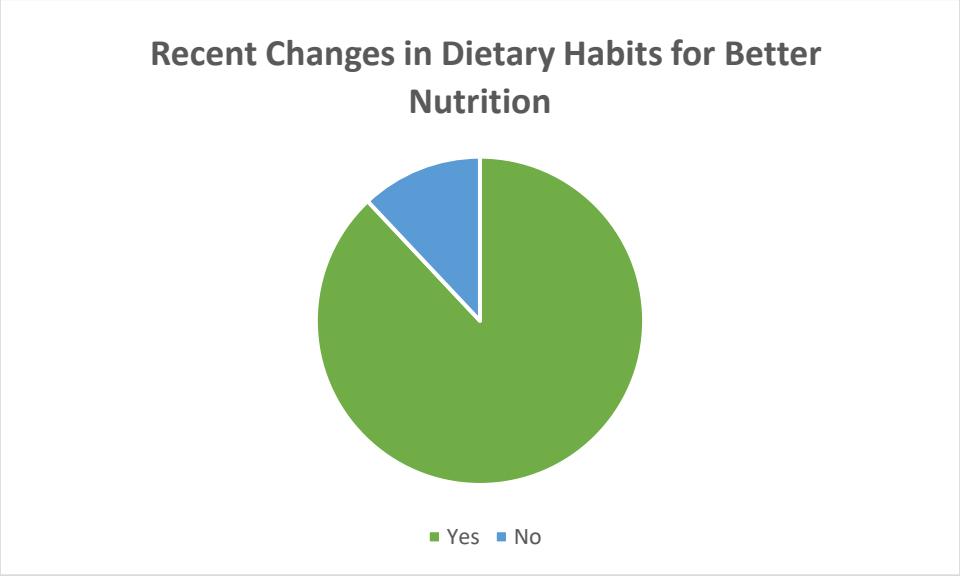

Figure 4.47

Table 4.48 Distribution of respondents-based on Recent Changes in Dietary Habits for Better Nutrition

S.NO	Importance of Nutrition for Holistic Wellbeing	No of Respondents	Percentage
1.	Very Important	15	30%
2.	Important	12	24%
3.	Neutral	18	36%
4.	Not important	5	10%
Total		50	100%

Table 4.48 illustrates the distribution of respondents based on recent changes in dietary habits for better nutrition. Among the 50 respondents surveyed, the highest percentage (36%) reported a neutral stance on the importance of nutrition for holistic wellbeing. Following this, 30% indicated that nutrition was considered very important, while 24% deemed it important. Only 10% of respondents expressed that nutrition was not important for holistic wellbeing.

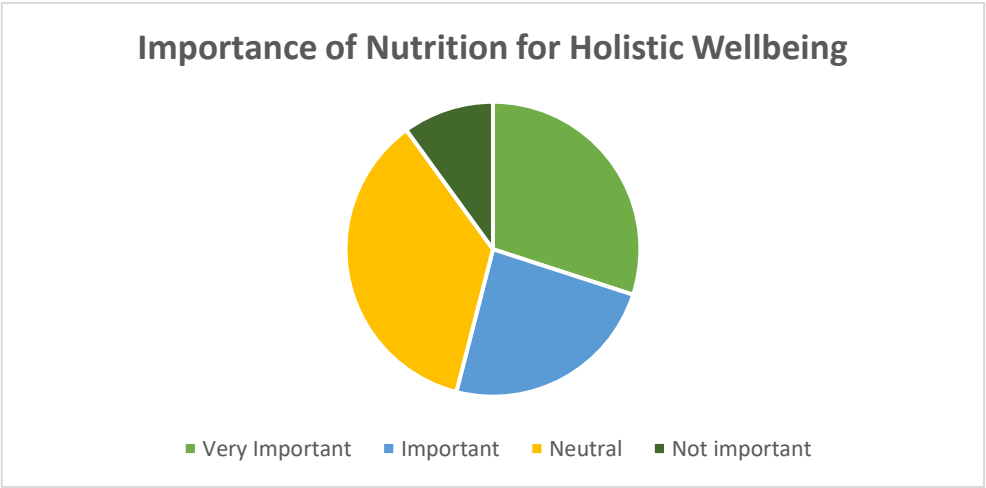

Figure 4.48

FINDINGS, SUGGESTIONS AND CONCLUSION

MAJOR FINDINGS:

- The age range of 26-35 encompasses the majority of respondents, constituting 44% of the total sample.
- All respondents are male, comprising the entirety of the sample.
- Most respondents, comprising 42% of the sample, hold a degree.
- The predominant marital status among respondents is married, comprising 80% of the sample.
- The predominant portion of respondents (54%) disclosed a monthly income below 20,000.
- The majority of respondents (44%) have families consisting of four members.
- A significant number of participants (80%) stated that they are the sole providers of their family.
- Nearly all participants, totaling 47 individuals (94%), are engaged in full-time employment.
- Predominantly, individuals with over 12 years of experience represent the largest group, making up 32% of the total.
- A significant portion of respondents, constituting 52%, stated that they work 10 hours or more per day.
- The majority, making up 82%, reported having irregular shifts.
- In terms of reasons for skipping physical exercise, the main factor cited among the 50 respondents surveyed was "Lack of Time," constituting 82% of responses.
- 52% of respondents showed awareness of nourishment.
- Exploring the reasons for lack of nourishment awareness among the 50 respondents surveyed, the predominant cause identified was "Lack of Time," with 48% citing it as the primary reason.
- The primary carbohydrate source for the overwhelming majority, accounting for 92% of respondents, was reported to be rice.
- Regarding meat consumption frequency, the majority, comprising 82%, reported consuming meat twice a week.
- The majority, accounting for 74%, reported daily consumption of fruits.
- Examining the distribution of respondents based on reasons for avoiding fruit consumption, it was found that among the 50 participants surveyed, the most common reason cited was the perceived expense of fruits, constituting 50% of responses.
- In terms of respondents' major sources of caffeine intake, among the 50 participants surveyed, the majority, totaling 76%, identified tea as their primary source of caffeine.
- Caffeine intake twice a day is reported by 70% of participants.
- Daily water consumption in liters is most commonly 3 liters per day, reported by 38% of the 50 respondents surveyed.
- Regarding the frequency of water consumption per day, the highest percentage (32%) of respondents reported consuming water every 2 hours.
- The majority (76%) of the 50 respondents surveyed reported consuming three meals daily.
- Economic challenges emerged as the most prevalent reason for dietary restriction among the 50 participants surveyed, constituting 50% of responses.
- Not smoking was reported by 74% of respondents.
- Among the 13 respondents surveyed, the most common frequency reported for cigarette consumption was 2 cigarettes per day, representing 30.77% of respondents.
- Regarding meals consumed from restaurants, the most common frequency among the 50 participants surveyed was one meal per day, accounting for 34%.

- The most common gap between meals reported among the 50 respondents surveyed was 5 hours, constituting 34% of the sample.
- The majority (70%) of respondents reported obtaining nutritional information from social media platforms.
- The majority of respondents, constituting 68%, reported consuming snacks, with tea/coffee being the most commonly consumed, accounting for 44% of respondents.
- Among the 50 participants surveyed, taste was the most frequently cited reason for food choice, representing 30% of responses.
- A significant majority, accounting for 92%, reported an absence of chronic illness.
- The majority, totaling 86%, indicated that they had not made any changes in their dietary habits for health purposes.
- Price was prioritized by the majority, comprising 64%, when making purchasing decisions.
- A significant majority, representing 66%, reported experiencing adverse effects of poor nutrition on their bodies.
- The most frequently cited reason, with 48% attributing their nutritional neglect to their occupation, was profession.
- The majority, accounting for 72%, reported not being aware of nutritional trends such as keto and paleo.
- A majority of 70% indicated they were not interested in nutritional trends.
- The majority, comprising 78%, reported not being aware of any government nutritional schemes. Among the 11 respondents surveyed, 54.55% indicated being beneficiaries of such schemes.
- An overwhelming majority, totaling 88%, acknowledged the necessity for nutritional awareness initiatives in both society and schools.
- The most common sleep duration reported was 6 hours, constituting 32% of the respondents.
- The highest percentage, at 34%, held a positive perspective on supplements.
- Among the 50 respondents surveyed on activities to avoid tiredness, the most common activity reported was the consumption of caffeine, with 50% of respondents endorsing it.
- Regarding the perceived role of cab companies in promoting nutrition, the majority, accounting for 50% of respondents, indicated that cab companies provide nutritional supplements as part of their role.
- A significant majority, totaling 88%, reported making recent changes in their dietary habits to enhance nutrition.
- The highest percentage, at 36%, reported a neutral stance on the importance of nutrition for holistic wellbeing.

SUGGESTIONS

As a social work professional, these research findings offer valuable insights into the nutritional perspectives of cab drivers, shedding light on their unique challenges and needs. The data underscores several key points. Firstly, it's evident that cab drivers, predominantly male and within the age range of 26-35, face significant time constraints due to their demanding work schedules, with many working long hours and irregular shifts. This time pressure is reflected in their reasons for skipping physical exercise and lacking awareness of proper nutrition, citing "Lack of Time" as a primary obstacle.

Despite this, there's a strong awareness of the importance of nutrition, with a majority recognizing the necessity for nutritional awareness initiatives. However, there seems to be a gap in knowledge and access, as indicated by the lack of awareness of nutritional trends, government schemes, and limited sources of nutritional information beyond social media platforms.

Economic challenges also play a significant role, influencing dietary choices and restrictions. Additionally, while there's a recognition of the adverse effects of poor nutrition on their bodies, many have not made changes to their dietary habits for health purposes, possibly due to barriers such as cost or lack of knowledge about healthier options.

Considering these findings, interventions aimed at improving the nutritional well-being of cab drivers should address their unique circumstances, offering practical solutions tailored to their busy schedules, economic constraints, and limited access to information.

This might involve initiatives such as providing affordable and convenient access to healthy food options, offering nutrition education programs tailored to their specific needs, and partnering with cab companies to incorporate nutritional support into their services, potentially by providing supplements or healthy snacks during shifts. Moreover, efforts should be made to raise awareness about the importance of nutrition for holistic well-being and to promote government nutritional schemes that could benefit this demographic.

By addressing these challenges and barriers, we can work towards improving the overall health and well-being of cab drivers, ultimately benefiting both individuals and society as a whole.

CONCLUSION

In conclusion, this comprehensive research provides a multifaceted understanding of the nutritional perspectives and challenges faced by cab drivers, a demographic often overlooked in discussions surrounding health and well-being. Through meticulous examination of various factors such as demographic characteristics, dietary habits, awareness levels, economic constraints, and occupational influences, we have gained valuable insights into the intricate interplay of factors shaping the nutritional landscape of this population.

The findings underscore the significant time constraints inherent in the profession, with long hours and irregular shifts posing substantial barriers to engaging in physical exercise and maintaining awareness of proper nutrition. Despite recognizing the importance of nutrition, many cab drivers grapple with limited access to information, economic challenges, and a lack of awareness about healthier dietary options. This is compounded by a general disengagement with nutritional trends and government schemes designed to promote better nutrition.

This signals an opportunity for targeted interventions aimed at addressing the specific needs of this population, such as providing accessible and affordable healthy food options, delivering tailored nutrition education programs, and fostering collaborations with cab companies to integrate nutritional support into their services.

Moreover, the research highlights the broader societal implications of improving the nutritional well-being of cab drivers, emphasizing the potential ripple effects on individual health outcomes, workplace productivity, and overall community well-being. By recognizing and addressing the unique challenges faced by this demographic, we can work towards fostering a culture of holistic well-being that transcends occupational boundaries, ultimately contributing to a healthier and more resilient society.

In essence, this research serves as a call to action for policymakers, healthcare professionals, and

community stakeholders to prioritize the nutritional needs of cab drivers and implement targeted interventions that empower them to make healthier choices. Through collaborative efforts and sustained advocacy, we can strive towards a future where all individuals, regardless of occupation or socioeconomic status, have equitable access to the resources and support needed to lead healthy and fulfilling lives.